

My head was aching yesternight
Today I feel I cannot write,
 So sore the megrim does me harrow
 Piercing my forehead like an arrow
That scarce I look may on the light.
 Wm. Dunbar, English Poet
 1560-1624.

PSYCHOGENIC ASPECTS OF HEADACHE. A SYMPOSIUM*

In any instance of headache, we quite universally look for organic causation. There is little doubt, however, that headache has a large psychic component, and not infrequently, it is entirely psychic.

*Dr. Leonard Gilman:*¹ A 48 year old man has severe incapacitating headaches, bilateral, constant, lasting from several hours to several days without relief by any of the known remedies. He has been getting increasingly worse for over two years after assuming charge of an office in which his duty is to supervise the activities of a group of scientists each of whom is more trained and capable than he is, by his own admission. He has managed to discharge his responsibilities well to all outward appearances.

His previous life history is not available in detail. It is known that he never suffered from headaches before and, so far as he can relate, has always been in excellent physical and mental health. An exceptional amount of medical work has been performed in the past five or six months since his admission to the hospital. In addition to the routine physical, neurologic and laboratory examinations, encephalograms, blood studies, electrocardiograms, allergy tests, histamine tests, spinal fluid examinations, endocrine and metabolic examinations have been unrevealing. Routine psychiatric examination has revealed no other symptoms. The family history is negative for headache, epilepsy, and neurologic disorders.

The character of his headache is unlike those commonly considered migraine. The pain is bilateral; there are no scintillae, no prodromata, no nausea, vomiting, etc.

The following questions are raised here: (1) Is it to be assumed that there is an etiologic organic or physiologic-pathology underlying the pain? (2) Can the pain be entirely

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¹Major, A.U.S.

psychic? (3) What could one say is the basic difference between "somatization reaction" and "hysteric conversion", both of which terms have been applied to this case at the hospital?

*Dr. Leopold Wexberg:*² Pain may be psychosomatic or conver-
sive, or both combined. Tension headache, due to intracranial vaso-
constriction, may be psychosomatic, and so may migraine. Headache
can be caused by insomnia, and the latter usually is psychogenic. On
the other hand, headache may be a symbolic expression of something
"giving me a headache", particularly something "I am trying to blame
on somebody," thus making him responsible for my headache. In this
way, it may become instrumental in expressing hostility, resentment,
or revenge, while, at the same time, serving as self punishment and
atonement for the patient's guilt. More often, headaches will be an
alibi, or an excuse for not accomplishing what the patient's ambition
wants him to achieve. This may be its meaning in the case discussed.
Naturally, the same tendency would have been served by a multiplicity
of signs and symptoms of another kind, or of different localization.
Why, in a given case, one symptom rather than another has been
selected, constitutes what has been called the problem or choice of
symptoms. This choice may be determined by historical-biographic
facts stored in the patient's (unconscious) memory; by the fact that
one symptom appears to be better fitted than any other for the un-
conscious purpose to be served; or by what Freud called "somatic
compliance", and Adler, "organ inferiority". Under the heading last
mentioned, "somatization reactions" are likely to be found. Freud
claimed that an organ which is the seat of neurotic symptoms invariably
carries libidinous significance (cathexis), which means that the neurotic
symptom, in addition to serving unconscious aims of other kinds, fur-
nishes also unconscious sexual gratification. There is some connection
between that theory and the adlerian concept of organ inferiority. Ac-
cording to an early statement of Adler's, "inferior organs are erogenic
organs", which means that they are "emphasized" by a pleasure-dis-
pleasure threshold lower than that of the rest of the body. The some-
what overplayed adlerian idea of overcompensation—painters with
visual defects, deaf musicians, etc.—points in the same direction.

Pain can be entirely psychic, just as auditory and visual percep-
tions may be entirely subjective, i.e., hallucinated. More often, what
is entirely psychic is its subjective intensity as based on a person's
sensitivity for pain. There seems to be individual variation of the
threshold for pain which is determined by physiology, as demonstrated
by E. Libman's findings. However, the objective response to a painful
stimulus, which can be measured, still is co-determined by subjective
experience which is beyond measurement, and always open to doubt
as to its "genuineness".

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Headache, like every pain, can be a background experience and, as such, is liable to be ignored when more important impressions or actions are in the focus of our attention. Emphasis can be shifted, however, and the pain, when emphasized, seems to be much more intense than it "really" is. What "really" means, referring to subjective experience, can hardly be defined, of course. Shifting of emphasis may serve unconscious purposes.

A 26 year old girl, under treatment for reactive depression and frequent splitting headaches, told me the other day that for the last week her headache had improved considerably. I have learned to distrust spontaneously announced improvements of that kind. So I just replied with a friendly smile and made no comment. Instead, I resumed the topic of our conversation which dealt with her most urgent problem, her inability to make friends, her aloofness and self centeredness. When I made a remark which was intended to hit a tender spot in her neurotic system, the patient, instead of answering, made the statement, almost triumphantly: "There are my headaches again!" It was fairly obvious that she was holding out to me her improvement as a reward for good behavior, to be withdrawn whenever I caused her displeasure, discussing what she did not want to be discussed. Also, headaches are a most popular excuse for everybody who wants to withdraw rather than join his friends.

*Dr. Frank S. Caprio:*³ The human body is a very complex machine operated by millions of cells whose function depends upon many internal and external factors. This body is able to function in many cases for over 70 years. The so-called normal person ignores his day by day organ discomforts, of which there are many, and manages to keep his mind concentrated on his life, his work and his social relations. The discomforts consist of many subjective and objective symptoms. A well integrated person knows that most of his body discomforts are of obscure internal origin. Many of the symptoms with obscure causation are due to or are concomitant with various degrees of frustrations incident to his social, personal and sexual drives which make the abnormal organ less tolerable to stimuli. Headache is one of the most frequent of such symptoms. Psychic frustrations, be it the death of a member of the family, economic reverses, disappointment in love, may so lower ones physical vitality as to lead to functional disturbances, and these, if unattended to, may lead to organic conditions. Conversely, a condition originally organic may, because of various difficulties which interfere with man's living, precipitate a superimposed neurosis. The tolerance of each one of us varies, some people succumbing to the frustration quicker than others. Health or development of a neurosis

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is dependent upon the ability of the person to adjust to love frustrations, to tolerate day to day body discomforts and control his patterns of reaction to them.

It is, therefore, not surprising to note that psychic situations are expressed by physical discomforts. To put it in other words, body organs and tissues are used by psyche as a vehicle through which to express our problems. In many cases, when the individual becomes sick in a particular organ, it would appear as if his entire life becomes concentrated on that organ. Or, as Freudians would put it, the organ absorbs the patient's libido and becomes libidinally invested (cathected). Strange as it may seem, however, for all the discomforts a neurotic patient suffers, he appears to get a certain amount of pleasurable satisfaction from the complaints. One only needs to recall the hypochondriac who loves to complain about his symptoms but resists treatment and is unwilling to get well and get rid of his symptoms.

It is in this light that we can understand the psychopathology of the headache mentioned in Dr. Gilman's report. For reasons of pride, security, or what not, the man is unable to resign from his position, nor can he carry on the work with any degree of success; hence the headache. One may speak of it as a conversion symptom or somatization. In any event, it is not so much a matter of whether or not physical pathology exists or not but as to whether the individual's drives are thwarted. We all want to live long and be healthy. Unhappiness, common to most all neurotics, tends to provoke feelings of physical and emotional insecurity and shortcircuits a desire to live long, which may explain why a neurosis is regarded by some as an expression of partial suicide. In the study of the psychology of a neurosis it is necessary to understand what the organs of our body are attempting to express. The choice of symptom is dependent on the nature of a particular conflict.

A patient aged 21, an only child, suffered severe persistent headaches since childhood. She came from a broken home, had witnessed her father, who drank to excess, strike her mother on many occasions. The father was also a philanderer. For some unexplained reason, she developed an unusual tender attachment toward her father. Following the separation of her parents, while she was still a child, she developed feelings of hostility toward her mother, who practically brought her up. She couldn't tolerate her mother making derogatory remarks about her father. On one occasion, in a fit of anger, she slapped her mother, an act which she later regretted.

Many psychic factors have combined here to produce the patient's headaches. She has been under stress of emotional confusion and insecurity; her head was dizzy and aching because it distressed her that father and mother did not love

each other and therefore from her point of view, could not love her. To her it was psychic pain, "mind" pain, "brain" pain. Her feelings of guilt because of hostility toward her mother, contributed to her headache because of tension created by guilt. Resenting the incompatibility of her parents, she has said to herself, "Why should I succeed in college when they are not interested enough in me to make up between themselves? My parents don't give me love, therefore, I am not going to make them proud of me, and how could I do it even if I wanted to when my headaches and my mind is preoccupied with anxiety over the family situation?"

At present she is beginning to realize that her basic feeling of insecurity brought on by the traumatic effect of her parents' divorce is one of the psychogenic factors in the development of her headaches and claims for the first time in fourteen years she has been experiencing relief from her headaches. She had decided to bring about her own divorce between her libido, and her brain and headache, and plans to return to college inspired by a desire to achieve some constructive goal, not for her parents' sake but for her own sake.

*Dr. Louis S. London:*⁴ Pain, I believe, may be entirely psychogenic. Freud was the first to demonstrate that psychic conflicts in hysteria were converted into corporeal symptoms through somatization of the libido, and that in all anxieties there is a somatic hysterical partner. This Freud explained by unconscious conflicts coming back to life in the form of symptoms. In Dr. Gilman's case I would strongly suspect an ungratified libido, probably due to sexual impotence with the headaches or tension as substitutes for orgasms. This is nothing new and has been described in analytic literature. To substantiate these statements I want to cite 2 cases from my practice which are fresh in my memory.

Case 1. A male of 40 who had been analyzed most thoroughly by another psychiatrist complained of continuous tension in the head which was a headache. He was very hostile to everyone in the world. In free associations he would express hatred and bitterness and would become very emotional, gesticulating with his hands and pounding the couch. He would do this from ten to twenty-five times during a session. After about one hundred sessions he calmed down, and his tension in the head ceased. It is now nearly two years since he has had any tension but I know that he leads a normal heterosexual life.

Case 2. A man about 30, married and the father of 2 children, was unhappy in his married life. His wife was

⁴Practicing Psychotherapist, Washington, D. C. Formerly, Passed Assistant Surgeon, U.S.P.H.S.

very frigid, and the couple never had satisfactory sexual relations. Together with many other symptoms such as sweating, vertigo and pains, he also complained of persistent headaches. He left his wife and experienced some relief. Later he was reconciled to his wife who cooperated more in their sexual life. When their sexual happiness improved, his headaches left him. He also ventilated many sadistic thoughts which probably contributed to the headaches. After their reconciliation, his wife complained of headaches which were probably from a hysterical identification. Although hostile to the examiner whom she held responsible for her husband's leaving her, she now became penitent and pleaded with the examiner for help. She was hypnotized once. The hypnosis was incomplete but her husband later said her headache disappeared for three months.

Personally, I believe that casual headaches should be ignored, as they are as common as colds but the persistent headache or migraine should be studied analytically. I am inclined to agree with many investigators who consider the migrainial condition as allied to epilepsy.

*Dr. Philip Litvin:*⁵ It is most interesting for the question to be asked about the etiology, especially the physiologic pathway, underlying pain. It is almost axiomatic to reiterate that only the conscious patient can react to pain. So consciousness is one of the requisites for pain to be appreciated. This consciousness must be local as well as general. Locally, the part must be not anesthetic, and generally the organism must be able to receive the stimulus that arises. The treatment of headache from the organic standpoint is either to remove the cause, or failing this to so modify the stimulus as to enable the sufferer to carry on with the underlying process unchanged. Thus the removal of the brain tumor or the removal of the irritative process will theoretically relieve the headache but there may be superimposed the remaining functional lesion, so to speak. The correction of refractive errors with their referred headaches is another example of the "correction or alleviation of organic headaches". Lessening of the stimulus or increasing the threshold is another method of treating headache. Thus stripping the covering of the temporal arteries is another method of interrupting the pathways of the headache, although the basic process is not interfered with. As a matter of fact, it is not known in many cases what the basic process is. The threshold to pain is relieved by the use of analgesics. In other words, the use of drugs often causes the raising of the threshold to pain with consequent relief. The use of these drugs may break the pattern of the pain pathway.

The case in question has no doubt been duplicated in more than one setting in each doctor's practice. Our society encourages minor

⁵Associate Professor of Neurology, Georgetown University Medical School. Lt. Col. A.U.S. (inactive status).

symptoms. To explain what I mean, it is not at all uncommon for us to be given an excuse that Mr. X will not be present because he has developed "a severe headache". This is a perfectly acceptable explanation in our society without the loss of face. So, in the case in question, the patient has released himself from the situation which is no doubt distasteful to him and has retained his "face". In addition, his reaction is such that he has not been overwhelmed and has not developed what has been commonly known as promotion depression.

It is very important to realize that psychogenic headaches can be superimposed on an organic basis.

A 36 year old white male with a college background was first seen because "he had fainted and struck his head while at work". Two days after the injury there was an obvious resolving contusion of the left frontal region and a classic black eye. His co-workers around him described no convulsive movements and there were no other signs of injury aside from contusion. As is too often the case I was asked to see him ten days after the injury because of "persistent headaches". I may say that all the tests "in the book" had been completed by this time. In getting the history the information was obtained that for some time there had been an office "flirtation" with one of his co-workers. He thought that he had the "inside track". A week prior to the fall he found out that his friend was going with others. She had given him an excuse of "having a terrible headache" on several occasions when she failed to keep their dates. The afternoon of his attack, his friend appeared in the presence of his rivals. He became very emotional and fainted. His headache stemmed from that time. Only when investigation revealed the mechanism and this was explained to the patient did the headaches cease. This "cure" has lasted for six months. I am sure that each one of us has seen such cases in other settings but probably where the psychopathology was not as superficial or evident.

*Dr. Ben Karpman:*⁶ Whatever may be the type of pain present, there must also be present some sort of physical pathology, however minimal or subtle. Unless we want to become dualists and assume that mind and body are independent, it will have to be more correctly assumed that body and mind are a unit, merely two aspects of the same situation. It is inconceivable that there should be present a psychic situation without a concomitant physical, and vice versa. As the late Dr. William A. White used to put it, "The psychē is as old as the soma", and Adolph Meyer proposed not to separate the two words but speak of these together as body-mind. We are all monist and go on the assumption of a unitary conception of the world.

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I am not quite clear as to what is meant by the "somatization reaction" and as opposed and different from hysteric conversion. We commonly speak of hysteric conversion symptoms when a body organ reacts in an abnormal way and in the absence of overt pathology. Thus, the heart may beat fast or the individual may vomit, or one may have a headache without there being any demonstrable pathology for the same. We then say the cardiac, gastrointestinal or cerebral reaction merely expresses symbolically the patient's emotional situation at that time. His heart beats fast in response to a fear of danger or some sort of discomfort. Under more normal circumstances the heart may beat fast in response to a definite physical situation. On this occasion the patient makes his heart react physically to the psychologic stimulus in a way he has been accustomed to know the heart to act under a physical stimulus. When the individual takes food against his will or he wants to express a reaction against the environment, his vegetative nervous system, in response to the emotional stimulus, makes the food come out in the form of vomiting. While in the physical sense this is vomiting, in a psychic sense it means rejection. In the case of a headache, these often develop in a situation of conflict and express the underlying tension engendered by the conflict and usually relieved when the conflict is satisfactorily resolved. The headache then expresses in a symbolic way the patient's difficulty in accepting his present situation and resolving the conflict satisfactorily. All these are therefore conversion rejections. That is to say, the psychologic situation is expressed by the body through the vehicle of one of the organs.

I would interpret the somatization reaction as being equivalent to hysteric conversion. In the case of the man under consideration, I would say that having had a background of success until two years ago, when he was put in a supervisory position to deal with people who are superior to him, it created in him strong inferiority feelings. He found himself in the position of a rat in a maze, not knowing how to get out of it. As long as he remains in the present situation, he will have headaches. He should get out but he doesn't know how he can gracefully leave the position without suffering loss of face, pride or prestige.

A case of psychogenic headache comes to my mind. It concerns a woman aged 35, a former patient of mine, who had been discharged some months before as cured. I shall give the account in her own words.

"I can go for several weeks without a headache, and then will wake up with one every morning for a week or more. They don't respond to aspirin at all; I used to take quantities of Pyramidon, when one could get it without a prescription, though I was a little bit afraid of it. The family doctor told me to take Empirin instead. At times the headaches are so regular that my husband will just get up in the morning and bring me a glass of water and two Empirin tab-

lets without my saying a word. I don't like to get up and get the medicine for myself. If I lie in bed, maybe fifteen minutes after taking the medicine, it goes away. It goes away if I get up, after taking the medicine too. It is a dull pain through the back of my head behind my ears. If I take the Empirin in the morning, I am rid of it for the day; if not, it may go away for a while but will return later in the day.

"Maybe it was for some other purpose I used to take the Pyramidon, because as I look back, I don't remember that I have been bothered so much by headaches, at least by these morning ones, except during the past few years. I think I used to have them in connection with my monthly periods. It was another doctor in Syracuse who gave me the only prescription that ever helped my menstrual pains, I think that prescription was in place of the Pyramidon, that he told me not to take.

"I can think of no particular emotional connection with the morning headaches. I have usually thought they were the result of constipation, as there seemed to be almost a tangible connection between my abdomen and the pain in my head. But it seems most likely too that there is more than a physical reason for my being constipated—that seems to be connected with tension, because that condition has seemed on several occasions to right itself if certain strains were removed. Then, too, the constipation and the headache are not invariably connected, though they frequently are.

"I cannot say how long I have been troubled by the morning headaches, perhaps for the last two or three years, or maybe even longer. Not more than five years, I think, anyway. I somehow associate them more with our being in this house, at least I don't remember their occurring elsewhere. I would say that for the last month or so they have not been nearly so frequent.

"It was in May 1941 that I developed a headache lasting for about six weeks; this was like nothing I had ever experienced before or since; it was almost like a muscular pain in the back of my head, as if I had strained muscles and it kept me awake at night and kept me from working in the day. I remember trying to work in the garden at the time, and when I went to bend over the pain would make me almost dizzy and I had to stop; I know I spent several days in bed and had a doctor come. He gave me pills or something that didn't help.

"There was staying with us at that time my husband's Aunt Mary. But I didn't associate my new headache with

Aunt Mary at the time, because it was nothing that she did that brought it about; there was nothing unusual that had happened in connection with her. If anything, I associated it with my friend Helen W. I think it was the very day the headache started that she had hurt me rather badly by a remark that seemed to me unnecessarily caustic and I had been quite seriously upset by it. I had at that time no other friends in this locality and she and I were quite close. It was not very long before this that my husband had found it necessary to take me out to the woodshed and give me a lecture on how to treat Aunt Mary, which had hurt me very much. Though I had not really discussed Aunt Mary with Helen, I knew I had her sympathy. I can see now how it might have seemed that if Helen were to break with me, I would just not have a friend in the world.

"What I don't understand is why she should have been connected with another physical upset of mine that occurred, I think in August of the same year. Helen had driven me in her car to town; we had had lunch in a drugstore and gone to see a movie, *Intermezzo*. On the way home I became violently nauseated, and as soon as I got home began vomiting and kept on vomiting until fairly late that night, when my husband got the doctor to come and give me a hypodermic. There was no definite unpleasantness with Helen on that occasion that I can recall, though I do have a vague feeling of discomfort in connection with that afternoon spent with her, as if some sort of unfavorable impression had been made that I cannot remember. The experience with the vomiting, which was something that had never happened to me before, might be enough to cause that in my recollections.

"It was sometime in May, while I had the headache still, that my husband discovered the house that we eventually bought; because he came home on a Saturday afternoon and insisted that Aunt Mary and I go right away and look at it, and I know that I had the headache at that time; I remember distinctly its hurting while I was going through the house.

"Well, we finally bought the house and toward the end of June we moved in. And since it was decided that Aunt Mary could not stand the strain and commotion of moving, my husband found a place in the country for her to go to for a week while we moved in. She was gone maybe a week or ten days, and it was precisely when the door closed after her on this occasion that the headache completely stopped and never returned, even when she did. Though when she telephoned me to tell me she wanted to return earlier than she had planned, (and my husband promised me he would get her

return delayed longer than had been first planned but this turned out to be impossible) I wept and it seemed as if the world had come to an end. And she came back but the headache didn't.

"However, it seems that it was after this that I began having bad dreams about Aunt Mary. In these dreams she would be doing or saying something that would exasperate me and excite me to an unbearable extent. The dream would be a mixture of hate, anger, exasperation, frustration—and these emotions would be so intense that I could not bear them and would wake up screaming and sobbing. These dreams continued up until the time we separated from her and went to another city (while she went to Chicago) in 1943—and it is my impression, though I'm not quite certain, that I didn't have any dreams of the sort while we were out of Washington, or even after we returned, except about a year ago, or maybe at some other time too when she wanted to come back and it seemed as if she would, in fact the date for her return was set. Then the screaming dreams returned but when the matter was settled I haven't been troubled with a screaming dream ever since."

*Dr. P. S. Graven*⁷ reports a case of headache with a remarkable localization.

It concerned an adult white male, aged 38, whose headache has been unusually persistent for the past two years. It was present day and night, sometimes maddening in character but sometimes only a small remnant of it would hang on. The pain was usually situated in the left temporal region and at intervals would shoot through the head to the right side. Sometimes a particularly intense pain was localized in the left parietal region from which it spread forward in an unvarying path into the region of the left eye and caused an unpleasant degree of photophobia. The analysis revealed that this man was playing mentally with the idea of suicide by shooting himself through the head. In contemplation, he imagined that he would point the pistol in the left temporal region and shoot himself through the head, or point it at the left parietal region and shoot through via the left eye, i.e., the bullet would follow the same path indicated by the course of the shooting pains. With the analysis of this situation, the headaches completely disappeared. Seven months later there had been no relapse. In connection with headaches, Graven maintained that suicidal ideas play a large part in many

⁷A Series of Clinical Notes on Headache. *Psychoanalyt. Rev.* 2:324-28, 1924.

headaches. The other case reported by Graven was that of a married woman, aged 30, who suddenly stopped the analysis because she was confined to her bed with a malicious form of headache. Pain focused in the region behind the eyes and extended laterally to beyond the right and left temporal regions. At times the pain was so strong that she felt as though the eyes would be pushed out of their orbits; at other times the pressure extended up and backward, so as to give the impression that the top of her head would burst or that the head would burst from all sides. Of particular note in her history, as concerning her headache, was the fact that her husband had a liaison with another woman which aroused terrific jealousy in her. She worried a great deal about it and for some unknown reason, she thought about her husband, fearing that he would commit suicide by shooting himself through the head. What actually turned out to be, was that she wished she could shoot her husband for his unfaithfulness but the wish directed against him recoiled against herself, i.e., retaliation. That is to say, she experienced in her head the sensations which she originally wanted her husband to experience.

*Dr. E. Guthheil*⁸ reports an interesting case of migraine in which he was able to trace the cause of migraine to deep-seated psychogenic factors and relieve it through a partial analysis.

The patient was a 32 year old woman who has been suffering from migraine attacks since the age of 16. The attacks were described as typical, coming on at the average of every two or three days, usually lasting a few hours, sometimes longer. For the most part, the attacks began with optic scintillation (migraine opthalmique) followed by nausea and tendency to vomit. The physical examination showed nothing of importance etiologically; heredity was negative. Frigidity and heart neurosis were the only neurotic symptoms worth mentioning. During the attack, the patient was very sensitive to pressure in her head. Sensitiveness to sound, light and certain other things which are characteristic of the sickness were also present. The revealing feature of this case of migraine was the fact that the attacks in most cases ended after a manifest sexual orgasm and lasted until spontaneous sexual relaxation took place. Sometimes the patient got several orgasms before relaxation and the end of the attack. She was unhappy in her married life and was incompatible with her husband. For these neurotic reasons she would choose extramarital partners. Analysis revealed that she was incestuously fixed on her father, and such relations

⁸Analysis of a Case of Migraine. *Psychoanalyt. Rev.* 21:272-99, 1934.

as she had, with her husband, were invariably in incestuous focus. Since incest is prohibited in our modern culture, she couldn't afford to have orgasms, which expressed itself in the form of frigidity as the outward symptom. Every now and then, however, especially in extramarital relations, the inhibitions would break through the barrier and she would have an orgasm, whereupon the guilt would come in, and because of the tension connected with it, produce the migraine. At the end of the treatment, which throughout the course was irregular and was never fully completed, it appeared that the migraine from a previous appearance of every second or third day, has now been reduced to once a month, either before or after menstruation. This was six years ago after the treatment was terminated. Guthheil maintains that in his experience most cases of migraine show, for the most part, an orgasm in masked form during the attack itself.

DISCUSSION

Dr. J. H. Conn:⁹ Mr. President, ladies and gentlemen; it has been a pleasure to listen to the excellent papers which have been presented this evening. The subject of "Headache" can be discussed under various categories—statistically, physically, descriptive and dynamically. From a *statistical* point of view it is of interest to note that when the Stockbridge records were tabulated, it was revealed that about 20 per cent of their patients complained of headache as a presenting symptom, in contrast with about 60 per cent of the patients who complained of gastrointestinal disturbances and more than 80 per cent who complained of anxiety symptoms. The symptom of headache, therefore, is presented with less frequency than symptoms deriving from other organic systems.

The *physical* factor must never be lost sight of; thus, for example, a physician who complained of headache for several years was completely relieved of his headache when he stopped smoking. If he had been under analysis, it would have been possible to associate his emotional conflicts with his complaints of headache. The same difficulty could occur in certain cases where hypoglycemic factors and the symptoms associated with eyestrain, fatigue or constipation would be overlooked.

From a *descriptive* point of view we have heard from several of the discussions that headache can be an "excuse" which is readily accepted in our culture. Three cases have recently come to my attention which might help to illustrate the problem of headache.

⁹Acting Chief Medical Officer of the Supreme Bench of Baltimore and Assistant Professor of Psychiatry at the Johns Hopkins Medical School.

The first patient is a young man of 28 who has had headaches since the age of 6. The frequency of his headaches in civilian life was about two a week. He could find relief by taking aspirin or by lying down for twenty minutes. In 1941 he was inducted into the Armed Services and while in the Army his headaches occurred about once a month. He described himself as a very conscientious person who drove himself too hard. At home he is well adjusted and he stated that he had no sexual problems. In 1945 he was discharged from the Army and a year later found work in a government agency. His headaches continued at the once a month frequency until after the birth of a baby in the summer of 1946. The baby was ill, kept the patient up night after night and he began to feel slowed-up, fatigued and was irritated by his lack of efficiency at work. In the fall of 1946 he became a supervisor of a dozen clerks, felt that he had to "keep after" his subordinates and began to experience an overwhelming sense of responsibility. Since his promotion his headaches have occurred several times a week in contrast to his previous monthly attacks.

Here we have an experience which is in keeping with the case discussed by the first speaker. We have first a *history of headache* extending back to the age of 6, then a period of relative freedom from responsibility while in the Army (when the headaches became relatively infrequent, occurring once a month as compared to the frequency of twice weekly when in civilian life). Secondly, there is a *particular life situation*, a period of fatigue at home, and the promotion to the position of supervisor with additional responsibility; and third, a *specific type of personality* which can best be described as compliant and anxious to please, whose chief goal is to be accepted by virtue of his overconscientious efforts to do perfect work. At this descriptive level we naturally have omitted certain dynamic features which occur in the next 2 cases.

The second case of headache is represented by a 43 year old married woman who stated, "I have had these headaches for the past eight years. Nine-tenths of them occur during the night (at 3 or 4 a.m.) and always before my menstrual period." The patient married seventeen years ago and has 3 children. Her husband is an energetic man who has violent tempers when criticized. He insists on having his own way and never consults the patient, either about his business or hers. Thus, on several occasions he had offered their home for sale and the patient was surprised when she received a number of phone calls from prospective customers, inquiring about when they could visit the home in order to

inspect it prior to sale. The patient is aware of her rage and has talked about separating from her husband. Their frequent, heated quarrels take place in the presence of the children and their home life has become unbearable. Her sleep has become disturbed. She awakens in the early morning hours feeling angry and hurt, and it is at this time that the headache occurs. The onset of the headaches began eight years ago when she had to face the fact that although her husband praised her for being "smart and clever" and talked of her "beauty", he never discussed his plans with her. At the time of the onset of her headaches he changed from being a salaried man to running his own business and had completely excluded her from any discussion of his future plans. Previously she had been proud of managing well on his modest income but now felt that she was of less use to him than ever before. The patient is a compliant type of person who has never been able to express her aggressiveness, and feels the need to participate intimately in her husband's affairs. They are sexually compatible and only in this could they literally get together. Patient is terrified of her husband's violent temper and is constantly giving in to him, feels consciously frustrated and has been completely rejected in spite of her repeated pleadings to be included in her husband's plans. She is an emotionally dependent, masochistic type of person, who has been talking of doing something about it for seventeen years and never has and probably never will. Here again, we have a specific type of person, a particular life situation and a type of response in which the symptom of headache predominates.

The third and last case is illustrated by a young man of 29 who speaks of himself as an extremely homely person and feels "completely rejected by the opposite sex". His father has been at a state hospital for six years with a diagnosis of manic depressive psychosis and the paternal grandfather suicided at the age of 50. The patient is an only child whose mother died of influenza when he was 14 months of age. The headache in this case appeared during an acute episode while the patient was observing a moving picture. He began to feel restless and anxious and did not know whether he should stay or go. He remained and began to experience severe headache which lasted for the next seven hours. When interviewed a few days later, he gave the following account of the factors which had influenced the headache. He had become extremely uncomfortable because of the love affair that he was watching on the screen. He said, "Why do some people get all the love and I get nothing?"

He felt that he should leave but finally decided to stay and felt particularly guilty. His guilt was composed of several elements: (1) He had been fighting an impulse to seek out a woman for the purpose of fellatio, which he had practiced in the past; (2) he felt an increasing awareness that he was responsible for his father's commitment to a mental hospital because he had refused to do something for his father just before he had entered the hospital; (3) he couldn't decide whether to go to a dance after the movie because of his fear of and need for rejection. A few days later the patient appeared with another symptom, namely that he had a fear that he was developing a cancer of the penis because there was some minor lesion which he now knew was the beginning of a malignancy. Now, it was obvious we were dealing with the problems of ambivalence, guilt, and floating anxiety which can be "attached" to different organs.

It should be emphasized that our knowledge in regard to the psychogenesis of headache is far from being complete. It is obvious that many patients are exposed to situational stress and suffer from guilt and anxiety without experiencing headache, that the compliant, emotionally dependent patients just described are very common in our practice, that the life situation that they have experienced, with suppressed rage, additional responsibility, the need for affection, are common to many patients, yet they do not complain of headache. Psychiatrists are too apt to glibly use words to cover up their ignorance of facts and gaps between sets of facts. The papers which have been presented have summarized in an effective manner that which has been brought to light by serious clinical investigation.

*Dr. Valentine A. Ujhely:*¹⁰ Since the advent of psychosomatic medical studies, and even before their time, in the psychoanalytic research of conversions and other anxiety equivalents, headache became a well-known manifestation of repressed emotional attitudes on the part of the individual ego. The causal structure, however, may differ greatly with each headache. I can cite several cases to support the contention of varied etiology.

Case 1:—This 39 year old cultured lady, a college of education graduate and part-time school teacher, after her husband's return from overseas, developed precordial pains, frontotemporal pulling headaches, drawing toward occiput. The fright induced by an M.D. due to his suggesting of a "possible" angina pectoris as cause, aggravated her headache. In twenty hours' analytic psychotherapy and eight hour's separate sessions with her 9 year old daughter, also including the

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analysis of twenty-six dreams, it was gradually brought out that during her husband's absence, she became vehemently infatuated with a very "gentlemanly" friend, and that she, being sexually starved, had the greatest emotional difficulty in exerting proper self control toward breaking up her "almost-begun" relationship. In the analysis certain guilt-feelings, induced by her superego, powerful ego-controls, that were "revolted-against" by the instinctual self, the Id, aggravated by a real life situation a few weeks before its coming to awareness at our clinic, when appeased and socialized, did no longer interfere with a gradual yet rapid resolution to complete disappearance of the headaches. Financial worries and disgust with the necessity to do part-time outside work, disgust with the occasional drinking habits of the husband also became conscious to her, giving her an opportunity to develop subtle technics against these damaging influences. Later she realized how she projected her nervous irritability and impatience into her relationship with her daughter, 9 years of age. This child was promised by her parents that there would be coming a little sister or brother but the patient had an accidental abortion, whereupon the child began daydreaming about having a real baby of her own that she fed on "real baby food." The child began playing with baby dolls, which she had not done for some time. The child became morose and defiant to both parents, and while this phase lasted, the patient's headaches became enhanced. Spanking the child did not bring about any relief, but, when the child dramatized her problems in the child guidance clinic of our Section, and later when she composed a drama on the "Model Home" enacted by her and a normal little girl chum, the mother gained excellent insight into this branch of her difficulties. Here the *Personae Dramatis* were nobly forgiving their parents for spanking them. She offered to the child the maintenance of a dramatic club for children so invited by the daughter, in the basement of their home, which rendered the daughter sweet and enthusiastic about her mother, and caused the patient to finally lose the last vestiges of her headache. The treatment was successfully ended by instructing the patient how she could keep her husband in a more romantic mood and how she could derive motives for self respect and joy rather than self criticism, or for suppressed and repressed affects, from the event above described.

The main therapeutic procedure here was a combination of cathartic and re-constellating analytic sessions and environmental re-arrangement leading to gratification.

Case 2:—A tall and beautiful former Army nurse, age 33, was referred because of sudden jerky left-directed neck and head tic, connected with occipital and forward radiating headaches, depression, insomnia, weakness and a desire to quit her civil service position. In the last ten weeks she was being tantalized by an older nurse, who threatened to discuss her secret past in the Army. Analysis given in twelve sessions by the doctor, assisted by individual psychotherapy of other types performed by the psychiatric head nurse under our direction, (eight hours), also Dr. U's hypno-oneiric test with artificial dream induction (five hours) brought about complete arrest of her symptoms, such as the tic, that meant saying "no" in the body language, the "worry" headache, fearing loss of prestige and efficiency, i.e., of security, together with lassitude and adynamia. Here, there were guilt feelings over having believed that her lover, so known to no one, would assume paternity while in military service. She hated herself for having allowed her son to become adopted by strangers. She craved for him, yet wished to hide her disgrace from her aged mother. She felt sexually much attracted to her doctor-officer-lover but despised him most ambivalently. She felt intensely insecure as assistant to the Medical Head Nurse at the Veterans Hospital, who "rode" her, because she was somewhat absent-minded due to brooding over the emergence on her horizon of an older Army nurse colleague, who, in turn, began to inquire into the circumstances of her pregnancy-discharge (from the Army) not yet known to the rest of the staff. There was deep depression. The induced dream was set up to serve ego-syntonic forces and demonstrate to her what deep human capacities she had that could be used in order to create fine works of general usefulness, and incidentally, *instead of crucifying* herself, she could just as well get rid of her guilt feeling, if she only would evolve her abilities to serve mankind, and by inspiring others, *live down* her past wrong deeds.

We succeeded in interpreting such a program to her from her own Catholic religious viewpoint, which she eagerly accepted,—then from the psychiatric and philosophic human viewpoint, into which she obtained a fairly enthusiastic insight also. We promised to assign her to our Neuropsychiatric Ward. All symptoms of headache, negational tic, depression and adynamic brooding absent-mindedness disappeared; she became eager to remain in the same hospital service, and lost all fear from the indiscreet older nurse, who was also asked by us to cease referring to the described intraservice history of our patient.

Case 3:—This 35 year old master-mechanic, married to an attractive, strong and decided personality, being the father

of 3 small boys, in the year of the 1929 depression, began having "terrible" headaches in the midst of sexual relations that inhibited further attempts. His libido and potency were greatly decreased. For a number of weeks he suffered with a fierce visual pseudohallucination of a large sharp ax, the edge directed toward his head, swinging far away on a rope and swinging back, stopping but a few inches in front of his skull. There was a compulsive-obsessive attitude of obligatory continuation, when this symptom periodically re-emerged, though he dreaded it. He knew it was not actually real in the outer world, yet he perspired profusely, had high racing pulses, transient hypertensive episodes, wild palpitations, frightening nightmares at such epochs. Analysis of fifty-four hours brought out his great fear from transmitting father's supposed gastric cancer onto his progeny; he also feared mental disease, though there was no such problem in the ascending or collateral family tree. Coitus interruptus was being practiced. He read a great deal of hereditary studies, and one night he dreamed that he played pitching horseshoes with the "kids." When his own horseshoe flew and stuck itself upon its mark, i.e., the stake, he awoke with a violent headache plus palpitation, his face was flushed, he was dizzy and confused. Analysis showed that he had read about the several phases, including prophase, metaphase, anaphase and telophase of mitotic cell division, and admired nature's handiwork of chromosomic splits assuming horseshoe forms. Then, symbolically, the horseshoe being pitched by him became equivalent of his spermatozoa, while the stake, in turn, represented his wife's generating organs. Deep in him there was a pronounced fear of having some more unexpected progeny in the depression years, as well as some uncertainty about transmitting disease.

With the aid of insight through psychocatharsis, plus medical information on the above fear-subject, he was led to invite consciously, rather than banish the feared visual symptom and "do it" together with the erstwhile spontaneous fear-symptom, thus decreasing frequency as well as the intensity of fear recurrence: the headache, synchronous with the forward stroke of the male organ during intercourse parallel with the fear of progeny, disappeared, when he became aware of the fact that his interrupted coitus technic of late months was to blame for his fundamental manifestations. He also reduced his thirty cigarettes per day to six, obtained his wife's collaboration to use preenceptive measures so that he could entirely eliminate his cerebral interference from his vegetative relaxation. His potency returned after re-establishing a feeling of security during intercourse; the headaches, depression and panic never returned.

Case 4:—This case illustrates a rarer type of conversion plus simultaneous somatization headache, in which there is a symbolically hidden ulterior motive thus not reaching a conscious level for fear of criticism by actual authorities or father figures, and there is also a direct autonomically transmitted somatization, namely, the *cephalgia due to over-secreting choroid plexuses under emotional stress*. This 19 year old corporal, son of a serious, self-effacing, hard-working and sober father, who suffered from headache up to twenty years ago, and of a sympathetic kind mother, who used to have periodic headaches during the patient's childhood, came to Walter Reed General Hospital (1948), seeking relief from excruciating headaches. He had enlisted eleven months previously, was assigned to do electrical wiring but first had to attend school at a distance. He disliked his assignment yet feared that his superiors would notice it and rate him as inefficient. He secretly felt that he was such indeed. Analysis of fifteen hours, plus other forms of psychotherapy by the occupational therapist, the psychotherapy nurse and the clinical psychologist were executed in rotation, altogether for thirty hours, to which five extra hours of Dr. U's hypnoneiric (dream induction) test and resynthesizing therapy were added. It was elicited that the young man was deeply impressed by his father's recent financial reverses, consensually began thinking of the latter's headaches that supposedly existed twenty years ago, and engendered with the great suppressed desire to get out of the Army and work for his father. At the same time, he felt guilty for not having been able to do so openly and honestly, since he was too proud consciously to ask for a dependency discharge. The headache symbol in this relation, thus, stems from both a preresolutional oedipal epoch (mother identification) and also from a postresolutional oedipal period (father identification). But, beside this, he powerfully and heroically suppressed his sexual urges directed toward his fiancée, whom he would have liked to marry without any contraindication between such a project's ethical legitimacy and the freedom from further Army duties but with the chance to help father by his civilian work-contribution. The most interesting part, however, was that when he came to us, there was a mild but definite bilateral papilledema, accompanying the headaches, and this being augmented by emotional stress, indeed became decreased by psychologic diversion, such as card games, and was completely relieved by mental representations of ways and means towards achieving his semi-consciously maintained hidden ambitions and organic cravings.

The organic manifestations included hazy ethmoid and frontal sinuses, pneumoencephalographic digitations of the cerebral cortex indicative of increased intracranial pressure, perfectly normal vision bilaterally, arterial hypotension and hypothermia, and at one time increased protein in the otherwise normal spinal fluid; but normal blood sugar and calcium at the height of the headaches, no drowsiness, normal alertness and intelligence and an absence of the prefrontal syndrome or of blackouts or of convulsions was present. The electroencephalogram showed a diffuse dysrhythmia but no paroxysmal focus.

No neoplasm could be suspected after painstaking neurologic studies. As a matter of fact, the variation of his pain-experience was more rapid, depending on mood-producing effectors as described above, than to justify any other correlation beyond a former virus-conditioned organo-functional matrix, lying beneath plasto-kinetic modulations by psychogenic factors.

When he was told that instead of transferring him to another duty assignment, he would be recommended for honorable discharge on medical grounds of disability, he became not only jubilant but he did so completely lose all presenting symptoms, overjoyed by this luck about his goal having become much nearer in attainability, that I was worried for a short while anent the Military Disposition Board's changing possibly its collective mind on the subject of discharging him from service. This eventuality, however, did not happen. Follow-up information proved no recurrences.

*Dr. Leo Kanner*¹¹: Children's headaches may be conveniently, though not too rigidly, divided into three categories: patently organic, migrainous and psychogenic. There is hardly a physical illness that may not occasionally be accompanied by headache; in some diseases, headache may be one of the most disturbing symptoms. It is a constant feature in intracranial tumors and in meningitis, is not infrequent in acute anterior poliomyelitis, occurs in cardiac, renal and hepatic disorders, is often associated with refractive errors, sinus infections and coryza, and may precede and accompany acute febrile conditions.

Present-day knowledge of migraine is still fragmentary. Migraine is more frequent in children than has been assumed until recently. Its nosologic position is somewhere between the unmistakably organic and the unequivocally psychogenic headache. It is well known that there is often a strong emotional element in the etiology and certainly in the aggravation or attenuation of migraine headaches of children (and adults). Psychogenic headaches of children are either situationally determined or of a neurotic character.

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The so-called headache of convenience, sometimes misnamed hypochondriacal, and fatigue headache are the commonest forms of the results of *situational* impacts. The question immediately arises why a child finds it "convenient" to have a headache or what is the source of a child's fatigue. Examination often discloses that the complaint and the sensation on which the complaint is based are defenses against strains and stresses threatening to overwhelm the patient.

The attempts of overambitious parents to cram "culture" down their offspring's throat deprive the children of the needed time for spontaneity. School, homework with emphasis on perfect marks, religious education, piano lessons and practice, dancing lessons, dramatic club attendance chase each other in never ending rotation. No time is left for the free play of recreational ease. Headache (often also stomach ache) gives some of these children their only opportunity to escape from the incessant grind and remind themselves that they have an identity of their own instead of being merely an ectoplasmic extension of their parents' ambitions.

Jerome L., 12 years old, normally intelligent, came to the clinic with the request: "I want you to take my headaches away." He had had frontal headaches for approximately six months. In addition to his regular school work, he went to a religious school for two hours daily, even during vacation periods. He took music lessons and practiced thirty minutes every day. He helped his younger sister with her arithmetic and ran errands for his parents and 2 older brothers. On Saturdays, he helped in his uncle's store. There was no time left for play. The type of work itself was not particularly exerting but the steady and uninterrupted activity created a state of permanent fatigue with headache, which disappeared promptly when sufficient time and opportunity for recreational outlets made this defense unnecessary.

Similar situational strain arises when a child is expected to perform on a scholastic level which exceeds his intellectual capacity. It is usually the conscientious child who responds with headache to the increased effort and the inevitable frustrations involved in the effort to keep up with the class requirements. The complaint is much too often misinterpreted as an alibi by parents and teachers. Removal of the strain by grade placement which is better adapted to the child's abilities tends to do away with the headache more effectively than the prescription of drugs or the accusation that the complaint is merely an excuse for "laziness."

Leroy B., 12 years old, had suffered from frequent headaches for several years. His mother reported: "I have given him aspirin tablets and made him lie down. The teacher sends him home from school with them. He complains of them three or four times a week. My doctor told me maybe

it is the tonsils and adenoids." T & A, however, had no better results than the aspirin. Leroy had a test age of 9 years and had been pushed up to the fifth grade. He had been working until late at night to keep up with his classmates. He also reacted to the strain with blinking tics. Parental expectations were brought in line with Leroy's abilities. A reshuffling of their attitudes and adequate school placement of the child relieved him both of his headaches and his tics.

There is, of course, also a strong situational element in the *neurotic* headache. But the personality difficulties have become more deeply entrenched, the relation between the psychodynamic pathogens and the symptomatic response is much more complex, and protracted psychotherapy is required in addition to situational relief.

In children, neurotic headache is hardly ever presented as the leading complaint; it is usually offered as a part of the problem, not as *the* problem for which treatment is sought. No matter how severe the headache is, it is not the admission ticket to the psychiatrist's office. The principal complaint usually centers around behavior which indicates obsessiveness, smoldering hostility and ineffectual attempts at emancipation from the demands of parental perfectionism. Most of the patients are crushed, defeated youngsters who have striven to attain parental approval by setting high standards for themselves, have found themselves foiled in their efforts again and again, and have fallen prey to a mixture of resentment, guilt and lack of self confidence.

Charles F., 14 years old, was brought by his father, an army colonel, a domineering disciplinarian, who in a rather accusing tone spoke of the boy's "tics and phobias," his "pronounced tendency to argue," his "fear of being happy because he might be unhappy the next moment," and his "damn methodical ways." Only then did the father mention that Charles complained of severe headaches accompanied by a head-shaking tic.

Colonel F. had divorced Charles' mother and remarried when the boy was 11 years old. Charles lived with his mother. He was never allowed to meet his father's second wife. The colonel, nevertheless, continued to run his first wife's household, which he supported financially. He had "very pronounced plans for Charles" and felt that the child failed to live up to his expectations. He dragged him from one physician to another. Deciding that Charles was not sufficiently interested in girls, he had him subjected to "a course of hormone therapy." He kept "talking" to Charles and "pointing out to him the value of education." He conceded that his son was "striving hard to make good" but was forever critical of the results.

Charles had little support from his mother, who had re-

jected him from the beginning. She had wanted a girl and was sorely disappointed. She saw in Charles a replica of her husband, whom she hated. Charles had this to say about himself: "I never had confidence in myself since I was small. My father always criticizes . . . I'd build something and he'd take it apart and build it over again. He treated my mother in the same way." He spoke of his severe headaches which he recognized as being related to his emotional problems. "The tics don't bother me. That's the thing that people see. It's the headaches that bother me. The only time when I have real rest is when I sleep." He brought his head-shaking "tic," which was voluntary to some extent, into close relation to his headaches which he tried to "shake off" in this manner, and offered this analogy: It's like he would see a tank of water. Everything looks all right to everybody else, but it would seem muddled to him. He'd shake up the tank to stir up the water so that he would not be bothered by what he had seen. His "tics" are something like shaking the tank; they relieve his headaches better than any medicine does.

Charles, who was very sick emotionally, was admitted to the Henry Phipps Psychiatric Clinic. Intensive psychotherapy had at first to cope with the father's methods of sabotaging all progress on his weekly visits to Charles. As the boy began to be freed of his pressures and anxieties, the headaches vanished with almost no symptomatic attention to them.

Both the situational and neurotic headaches of children clearly are symptomatic manifestations of inner distress; treatment must be addressed to the underlying strains and conflicts rather than exclusively to the symptom itself.

SUMMARY AND CONCLUSIONS

I. Origins.

1. Headache may accompany any physical illness, and be entirely physical in origin and character. However, by far the greatest number of headaches observed clinically are not of physical origin or character.

2. Some headaches, such as for instance migrainous headaches, stand midway between the unmistakably organic and the unequivocally psychogenic headache. Strong emotional factors are often present and such may aggravate anew the existing headache.

3. By far the greatest number of persistent headaches, including migraine, met with in practice, are of a psychosomatic nature. It is not contradictory that psychogenic headaches may be superimposed on an organic basis.

II. Types of Headaches.

1. Casual headaches are very common and may be ignored but persistent headaches require definite attention. They do not respond to physical or medicinal measure. However, such headaches, including migraines, often respond satisfactorily to psychotherapy.

2. The situationally determined headache may be: (a) the headache of convenience; (b) the fatigue headache. In children, severe limitation of their spontaneity may drive some of them to escape the grind by way of headache, as does the imposition of tasks beyond the child's need, ability or willingness to achieve; while the removal of the strain promptly tends to remove the headache. A situational headache may superimpose itself upon the neurotic headache, in which case protracted and deeper psychotherapy may be needed in addition to situational relief.

3. Neurotic Headaches: About 20 per cent of neurotic patients complain of headaches as a presenting symptom. Neurotic headaches are hardly ever presented as the leading complaint but more often as a part of the problem, the latter being indicated by obsessiveness, smoldering, but not fully expressed, hostility toward the parents, guilt and lack of self confidence. Associated physical factors (such as hypoglycemia, eyestrain, constipation) should not be overlooked.

III. Nature of the Psychogenic Headache.

1. Pain can be entirely psychic; especially subjective may be its intensity.

2. It presents itself as a somatization reaction concomitant with a great variety of physical states such as vascular, gastrointestinal disturbances or genital dysfunction.

3. Existing headaches may be diminished with the decrease of strain and likewise may become aggravated in degree and frequency with an increased strain and additional responsibility.

4. Purely psychic situations, especially unconscious conflicts, may often be expressed by physical discomforts; this is spoken of as somatization of the psychic situation. This somatization may sometimes be entirely of a psychosexual nature. Some analysts believe that most cases of migraine show an orgasm in masked form during the attack itself.

IV. The Symbolic Meaning of the Headache.

1. The headache may express in a symbolic way the patient's difficulty in accepting the situation as it is and failure to resolve the conflicts satisfactorily. It may be a symbolic expression of something "aching" in the head, and may act as a medium and a means of expressing a variety of ungenerous and unhealthy emotions, such as hostility,

guilt, frustration, insecurity, pride and the thwarting of drives and ambitions.

2. Headache may present a secondary gain in an assumed state of sickness.

3. It may express symbolically prolonged worries that are well grounded in reality and that are progressing toward a dangerous climax (threat to one's economic security, to possible loss of prestige).

4. Headaches may result from patient's recoiling to personal hostility and the resultant torturous guilt feelings; self punishment is a fairly common dynamic ground for the symptom.

5. Global retreat from duty and planned effective sequence of action.

V. Psychogenic Determinants of Headache.

1. Particular life situations (situational stress) such as marital difficulties with the need for but unrequited affection, repressed rage, etc., may be causative factors in the development of headaches. The headache takes the place of undischarged rage.

2. The choice of headache instead of another reaction as a neurotic symptom is dependent largely on the nature of the particular conflict and the history of the patient, especially as concerning the circumstances under which the symptoms developed. We must understand what the organs of our body are attempting to express. Even the localization of the headache, frontal or occipital, may be psychogenically determined.

3. In individuals with well developed neurotic symptomatology (guilt, anxiety, etc.) headache may easily superimpose itself when such an individual is confronted by a relatively minor frustrating situation.

4. In some childhood headaches, a strong etiologic factor of introjecting and assimilating parental or sibling symptoms can be traced.

VI. Personality Make-up and Headache.

1. Headaches are particularly apt to occur in specific types of personalities, e.g., the compliant and anxious-to-please type of individual.

2. In many paroxysmal attacks of migraine, a personality defect consisting of inability to assume adult responsibilities, may be detected.

PSYCHOGENESIS OF A SCHIZOID MANIC

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The concept of the term manic depressive psychosis has undergone many changes in the past four decades. The type reactions vary and have been described as the manic type, depressed type and mixed type. There are also many forms: alternating, circular and stuporous. In the past twenty years one has heard much of schizoid manics. As the term implies, it is a mixture of manic and schizophrenic symptoms. It is, therefore, allied to both manic depressive psychosis and schizophrenia. Schizoid manics are more frequently found in psychiatric hospitals than in private practice, as they are more difficult to treat and are apt to become disturbed, maniacal and even assaultive.

The writer's analysis of the following case represents fifty sessions, at the end of which he liberated a Jehovah complex which had been precipitated by an excited episode. It was necessary to place the patient in a State hospital where he remained for several months, going through a typical manic attack. When he quieted down, he was transferred to a private sanatorium where, two weeks after admission, he ended his life by taking an overdose of barbiturates.

SESSIONS 1 TO 10

A 39 year old physician complains of being depressed but does not exhibit it in his face. He is voluble, describes himself as hopeless, and believes he suffers from schizophrenia. He tells of many hospitalizations and claims to have had his first breakdown when he was a pre-medical student about eighteen years ago. He says that during one of his hospitalizations he compared himself to Christ and had visual hallucinations. "Since becoming a doctor," he states, "I have had four definite attacks of depression from which I have never really recovered. I have even subjected myself to shock therapy but I think it did me more harm than good." He readily admits many attempts at suicide and describes three of them. "Once I injected adrenalin intramuscularly but it only made me sick. On another occasion I tried to induce an embolism by injecting adrenalin into a vein. A while after that, I tried to kill myself by taking a large dose of a hypnotic but it only made me groggy."

One of his greatest fears has been that his abnormality would be observed and he has therefore been staying at home under the care of a male nurse, who even cuts the patient's hair since he is unwilling to go to a barber shop. He says he has been under the care of another psychiatrist but did not dare to go to a medical building lest he be recognized as a psychotic. He feared lying on the couch and was only

willing to meet his former psychiatrist at irregular intervals and at hours when other offices were closed. He admits falsifying his dreams to this psychiatrist but says he has fantasied himself as a surgeon having a wife and 6 children and being of a different race.

At the end of the interview, he consents to regular psychoanalytic treatment.

He objects to lying on the couch at first but later acquiesces. He begins by relating a dream about the analyst and his family.

Dream 1: "I see you and your wife. There is also a boy and girl. Your wife wears glasses, and you introduce your wife to me and say she is considered capable."

Interpretation:—The dream brings up the question of transference, which is important in every case. It indicates negative transference. The analyst's wife represents the feminine component of the patient, who likewise wears glasses. The capability represents the ability of the patient, who considers himself an erudite physician but also has marked feelings of inferiority—especially regarding his sexual life. The boy and girl are his sister and brother. They certainly do not represent the children of the analyst, because the patient knows nothing of the analyst's personal life, and this is only his second visit.

In relating ideas associated with the dream, he says, "I have been thinking of suicide for many years and will some day go through with it if I don't recover. The suicide drive has been with me as far back as I can remember. While at school I vowed I would commit suicide if I failed in my examinations." Then he discusses schizophrenia and says, "I have a great fear of mania and hospitalization." He next talks of marriage and asserts that he wants to marry a girl of a different nationality. He states, "I think I was discriminated against because of my nationality when I was an intern and when I was hospitalized during one of my attacks, my nationality was criticized."

"I began active practice nine years ago, but was never successful due to my frequent attacks." (This seems to have been one continuous attack with acute exacerbations, since he apparently never recovered from the original attack.) He complains of being underweight and declares, "During the last year I have dropped from 170 to 130 pounds." (A weight loss in mental disease is not a bad prognostic sign.) "I fear marriage but want children. Perhaps my condition would predispose my offspring to mental disease." He admits having had an active autoerotic life for ten years and wonders if he can ever attain a normal heterosexual life. He gives his reason for masturbation as a dread of venereal disease. "I developed this fear after my grandfather and father warned me of gonorrhea and syphilis when I was in my

teens." Then he goes into minute details of the work of his grandfather, who was a butcher. In discussing his masturbation, he says it occasionally relieves his tension and enables him to sleep, although he has suffered from insomnia and been dependent on sedatives for years.

"I am reticent and seclusive and afraid of meeting people. When I go to the movies, I can't sit relaxed. I seem to be under continual tension and have to sit on the edge of my seat. "For two years after medical school, I was in a very depressed state and tried to commit suicide on one occasion, but during this time I took a postgraduate course in physical therapy."

Then he gives a detailed account of his father's heritage, tracing his business career through many trials and tribulations to eventual success. He says that his father died nine years ago and left him a considerable share of his estate. He describes unsuccessful psychoanalytic attempts that have been made to help his mental state and tells how many of his colleagues scoff at psychoanalysis and say it is a racket. He also mentions reading of many physicians who have been analyzed and later committed suicide. He claims that he made over two hundred visits to a psychoanalyst but confesses that he refused to go to his office and often met him in his automobile instead. He says he has also been subjected to irritative therapies, such as metrazol and electric shock.

He describes his childhood and his interest in sports, fishing and social activities. He traces his anorexia to his childhood and says, "For many years I have been unable to eat properly and have depended on sedation for sleep. For long periods of time I have kept myself confined to my office, which I have rearranged continually, especially when in hypomanic states." Voluntarily he talks of his sexual life. "When I was fourteen, several boys and I planned to engage in mutual pederasty but when my turn came, I refused. When I was fifteen, I went to a camp and began to masturbate while I was there." He emphasizes that he never fantasied men but always women. "Once several years before that, I found a condom in my mother's bedroom, and about that same time she asked me if I ever played with myself. When I was eight, my uncle who was about 18 or 19 showed me his penis and said, 'Isn't it juicy? Don't you want to suck it?' During my second year at medical school I had an operation for an undescended testicle. In my third year I was very nervous and talked to an old general practitioner about it. I had planned to join in practice with this doctor after graduation

and considered him a very good friend. He told me to forget about my nervousness. Just before entering medical school, I took a trip to Florida on a steamer. I met a girl and fell in love with her. We kissed each other passionately, and I told her how much I loved her but I couldn't persuade her to have intercourse. I tried to fantasy her in masturbation but couldn't go through with it. I think my nervousness began when I failed in trying to have an affair with this girl.

"Shortly after this disappointment I had an excited episode and was taken to a state hospital in a state of panic. I was discharged after being there for only a short time but I remember that while I was there I met a famous neuropsychiatrist, Dr. ———, and discussed my case with him. Right after this I took a postgraduate course in physical therapy and at the time began treatment with a private psychiatrist." In another visit he enumerates the phobias that possess him. He is particularly concerned about the fear of leaving his quarters and mixing with people (agoraphobia). "I cannot decide," he says, "whether I should or should not go out into the street. This continual conflict creates anguish which makes me feel tense. If I take a cab, apprehension follows, an anxious expectation that something may happen."

Then he changes the subject by telling of writing a note to his former psychiatrist about the spelling of words backwards and calls it "hyperacousis." He states that a noted author has also written about this. He mentions again that suicide thoughts continually dominate his mind and that to him ending of his life means security, but adds that this idea is counteracted by "family sufferings."

He speaks of his masturbation and fantasies of women always in an act of rectal intercourse (masked homosexuality). He claims that he has had no sexual relations in eight or nine years. (It is questionable to the examiner if he has ever had any real sexual intercourse.) He recalls that following his heterosexual attempts which ended eight or nine years ago he had a manic attack which lasted two weeks and that he had to go to a private sanitarium where he was under the care of two psychiatrists. He also mentions again his operation for an undescended testicle and the fact that afterwards he was hyperactive sexually. Suddenly he complains of fatigue and says he cannot talk further, thus terminating the session abruptly (negative transference).

On the next visit he is very depressed and says he had to take sedatives, although he has been advised not to use any drugs. He claims that he tried to fall asleep but was

unable to and waited until three or four o'clock in the morning before resorting to sedation.

Dream 2:—He recalls having a dream but all he remembers is that an old girl friend was in it. Associating further to this girl in the dream, he says they cohabited night after night three and four times but to the examiner his account appears to be a description of fantasy life. He states also that at the time he had an intense venereophobia and used prophylaxis. He claims that this sexual activity precipitated a depressed episode which lasted for several months. "At this time," he says, "I was sharing my room with another student. I told our psychiatry professor about my symptoms and he recommended a week's stay in a sanitarium. This depression was very severe and I again planned suicide. After I left the sanitarium, I went around to pawn shops trying to buy a pistol. My mental condition was so serious that I gave up medical school for a year, but I was able to finish later and got my M.D. degree when I was 24." Following graduation, he says, he had a period of excessive sexual activity and resorted to the practice of fellatio. He still had his venereophobia and continued to have fantasies of sodomy with women. He declares, "I never could practice this form of perversion but on several occasions during intercourse, I stuck my finger into the girl's rectum. I was always partial to the buttocks of women, and whenever I saw a well-formed one I would become very erotic."

Dream 3:—On another visit he begins by reporting a dream fragment about a classmate. With this fragment he associates the fact that his classmate specialized in surgery and that he always has felt humiliated whenever he encounters this classmate. He complains of weakness. When he takes a walk for about half an hour he feels exhausted. At night his sleep is restless and even with sedation he cannot get rest. He also complains of tension in the frontal region of his cranium. He admits that for three months he has been resorting to sedation continually.

Again he digresses to sexuality, describing an attempt at coitus with a nurse. He says that since she was menstruating he suggested fellatio. She refused but agreed to let him have intrafemoral relations by placing a handkerchief between her legs. He concludes the session by describing a long series of depressions which lasted for five years.

The next day he is more voluble. He says he tried to sleep without a sedative but was again restless and complains of tossing all night in his bed. He seems to be very much concerned about his weight. He also talks about his

genitals and says, "I used to have a small penis, probably because of my undescended testicle. After the testicle was brought down, my penis got larger. I measured it and found it to be six inches. I was so obsessed by the size of my penis that I wrote to a medical journal asking for advice about the enlargement of a penis in one of my patients. I received a reply that there was no medication for any male at the age of 36 which would correct this difficulty. Then I tried endocrine treatment without any results. I questioned my girl friends about the size of my penis but none of them said it was small. I also tried to enlarge my testicles by squeezing them gently in my hands. I tried to enlarge my physique, too, especially my arms and forearms."

Next he talks about his childhood, and says that he was very obedient and when told to sit on the stool would stay there indefinitely until called for. He declares that his former analyst told him he had a mother fixation but that he did not believe it. His reason for disagreeing with this analyst is that he left home at 15 and has never been home since. He tells of controversies with his father, who often told him he was contributing worries that would eventually cause his father's death. "My father often said, 'Your name should be written on my tombstone.' I quarreled with my brother often, and although we were in the same home, our basic environment was different, because my brother was considerate of our parents while I was very selfish. I did not get along with my sister either. She was four years younger. We often quarreled during childhood and she would always destroy my possessions." After discussing his family life, thoughts of early sexuality come to his mind. He remembers that when bathing him at 4 years of age, his mother said, "Are you playing with yourself?" After that experience he says he never allowed any female to enter his bathroom. At the age of 7 or 8, he claims he was already curious about sexuality and remembers seeing a condom on the bureau in his mother's room, as mentioned in an earlier session.

In another visit he says, "I dreamed there was a group in our apartment, and my father came into the room dressed in a seersucker suit. I helped my father to lie down, as I thought he was tired." He associates thoughts that his father died of a coronary occlusion after several doctors had examined him and found nothing wrong with him. He then talks of many of his classmates who were stupid in medical school but who have become very successful in the practice of medicine.

Then he again goes back to his sexual life and says,

"It may be ten or twelve years since I had an actual sexual experience, although on many occasions women suggested sexual play to me. I always evaded it because of the fear of syphilis or some other disease. I often necked with girls and after becoming very excited would go home and masturbate. During the last ten years I have masturbated two or three times a week." He claims that he now sees that his last three depressions were precipitated by sexual attempts. On each occasion an attempt at coitus would be followed by insomnia and loss of appetite. He says he also realizes that he has not been well for ten years and spends the rest of the session describing in detail a hospitalization which lasted five months.

The following day he said, "Yesterday after I left here, I felt relaxed and was not agitated. I walked home, shaved, and listened to the radio. I felt fine and the impulse to commit suicide was almost gone. Today the impulse to commit suicide has returned and I think a good time to do it would be while my mother is away in New York. In this way she would not have to endure the shock, and I want to spare her an emotional upset." In his free associations on the couch he tells that when in New York he was interested in a nurse at the hospital where he was interning. He developed a state of excitement one day at the hospital, and during this episode he yelled at her, "Come and fuck me!" A woman assistant superintendent dismissed him, even though he told her he had a brainstorm and pleaded with her not to dismiss him, as it would interfere with his future and his love life. Then he shouted at this woman, "You are a homosexual yourself, but you would make a good piece." The commotion brought the superintendent, who also ordered the patient out. The patient says he then threatened to shoot him and the police were called. He was sent to a county hospital, where he was examined by a psychiatrist, who performed a lumbar puncture on him which was negative. The patient says he continued to be hyperactive and was so noisy and threatening that he was placed in a camisole. He says that the following day he developed ideas that he was Jesus Christ and was removed to a private sanatorium.

After relating this painful episode the patient was dismissed from his analytic session early to avoid the liberation of too much significant material at one time.

The next day:—The disclosures of yesterday's session upset him, and he reports late for the session today saying that he feared the physicians on the same floor of the Medical Building would see him. He related a small dream fragment.

Dream 4:—"I was at a sanatorium and got metrazol treatment." To this fragment he associates the details of a trip to a sanatorium and how his former analyst took him there and said that he was analyzable. The patient says that he did not think he was. He then tells about his experiences at a private hospital where he had twenty-two shock treatments.

SESSIONS 11 TO 20

After several days, he is noted as apparently still greatly disturbed. He tells about his phobias of going to the barber shop or having his shoes polished. Then he relates a dream fragment:

Dream 5:—"My mother gave me a meal. In the center of one of the dishes was a prune." In his free association thoughts he says he believes that there were three dishes that he could not eat and that he would often refuse food, because he thought that if he ate, he would live and he really wanted to die. He also states that he usually did not like prunes. This fragment is quite important; for it is incestuous in content. There are 3 children in the family—2 sons and 1 daughter. He was his mother's favorite son, a so-called "mama's boy" (typical Oedipus complex). It is a wishful-filling dream to get his mother's love.

On another visit, he is very affable and cooperative. He says he now believes in analytic therapy, but this remark is an effort at evasion. He talks of his home and says he eats better. He claims that he showered and washed until 2:30 a.m. but could not fall asleep last night. Finally, he had to resort to sedation and had four hours of sleep but awoke feeling dejected. He says that his phobias persist; in fact, they are increasing. He fears his insomnia and says, "It is a symptom of a major psychosis, but I have passed the peak of depression, and my digestive disturbances have decreased until I no longer have to take soda."

Then he immediately digresses to his sexual life and says he now considers it improved, because he has not masturbated in four nights. Next he reminisces about playing with a nurse and says, "I tried to have intercourse with her by pressing against her, but I could not induce an ejaculation." "I am happy that noise does not disturb me and irritate my nervous system. I also am free of symptoms of a compulsion to try to spell words backwards. A noted author has written about it." He claims that his suicidal ideas still persist and goes into a differential diagnosis of his case, which he now believes rests between hysteria and neurasthenia.

Dream 6:—On his next visit, he reports a short dream fragment: "I am with a crowd of people. My mother, brother and sister are around, and I have to leave for an appointment." He interprets this dream fragment as a thought of suicide. He reasons that his best security and restfulness is death. He admits that the day before he masturbated and used this as a therapeutic agent to relieve nervous tension. He fantasied a girl he once rubbed up against. This experience precipitated an excited episode. He associates two sadistic episodes when he was 11 and 12 during which he often stuck whips into the anuses of horses and once whipped a dog. He again tells how his Dad lectured to him on the danger of venereal disease, and how when he consulted the physician who had brought down his undescended testicle, the doctor said to him, "You are too young to be nervous." The next day he reports having a very restless night, resorting to sedation and only sleeping two or three hours but he remembers a dream fragment.

Dream 7:—"A colored man cut my hair in my office. This colored man resembled an actor on the screen. I remembered seeing mud on the man's boots." He cannot associate to this dream fragment but tells of masturbating with his maternal aunt in the fantasy. He recalls that this fantasy occurs frequently. He always fears going to the barber and having his hair cut. We can interpret the symptom of fear of going to the barber as a fear of castration and the colored man wearing boots as representing sexual prowess. The patient is impotent and can be regarded as a weakling and cowardly. We often talk of a man "dying with his boots on" as representing daring and courage. His association to the masturbation fantasy represents his incestuous attachment to his mother, who is replaced by his aunt, her sister.

On his next visit he has no recollection of a dream but a certain word comes to his mind. The word is "Arcade," and he associates a motion picture theater by this name, when he was a small boy. Here he would sneak in without paying admission, although he was then a Boy Scout and taught not to cheat. He again tells of his irritative therapy and how he was subjected to eight metrazol and twenty-two electric shock treatments. He does not recall any aura but remembers that following the treatments his speech was slurring. The next day he relates a short significant fragment of a dream which releases his latent homosexuality and an increase in volubility in the next few sessions.

Dream 8:—"You (analyst) tell me that my rectum is just like a vagina." To this dream fragment he associates

anal eroticism. He often tries to extricate fecal matter from his rectum, evidently securing gratification by inserting his finger, which symbolizes a phallus. Two years before, he had a swelling of his rectum. At first he asked his former analyst to open it but when he was refused he tried to treat it himself. He made no progress and had to consult a surgeon. The free associations which liberated his anal eroticism caused a reaction in him today as he tells of developing anguish on his way home. He had a panic and vomited. Then his suicidal fantasies recurred with the greatest intensity. He says that for three years he has been planning suicide. The year before he tried it by inserting adrenalin in his veins. Since then he has not made any serious attempts to commit suicide except that occasionally he pounds himself on the chest. He has thoughts of renting a canoe and drowning. In this way he could avoid a scandal in his family. He realizes that his state of panic is symbolic of something unconscious but does not know what it is. His first panics began ten years before, and he remembers on one occasion leaving a barber shop in the midst of a haircut, telling the barber that he had to make an urgent call.

SESSIONS 21 TO 30

On his next visit he says his anguish has decreased; he slept better at night. He had no dreams but awoke refreshed. He tells he indulges in alcohol occasionally but really does not care to develop a habit. He speaks of his internship and goes into details, saying that he was a good intern but even at that time he was not entirely well. On one occasion he passed a derogatory remark about a nurse and was summoned to the superintendent's office. This was thirteen years ago. He shows excellent insight in his past and present mental state. As a young child he had asked his father whom he liked best among the 3 children in the family. His father would always hold up three fingers and say, "Which finger do I like best? If I cut one, it will hurt. They are all the same to me." Patient then ends the session abruptly, saying he wants to commit suicide. In it he seeks peace and security in oblivion—psychoanalytically we may interpret this as a desire to return to his mother's uterus.

Dream 9:—On another day he relates a small dream fragment. "Some one tells me to do this or that. I awake in terror."

In free associations he tries to review his case and says his former analyst never interpreted a single dream. Upon one occasion he brought a dream in which women were lying in the form of the number 69. He asked his analyst for an interpretation but did not get it. He talks of many things

that he has discussed in previous sessions. He again tells that one year ago he tried to commit suicide by injecting adrenalin and developed auricular fibrillations. He then became apprehensive and wanted to live. Two years before this, he also injected adrenalin in his thigh. He tried to inject air in his veins but failed. Three years before, he tried to fall accidentally and kill himself. He has often thought of hanging himself and even tested it on one occasion. He is continuously seeking a natural cause of death.

Dream 10:—Two days later, he relates having the recurring fragment of a dream of his mother's death ten or twelve times during the last few years. He fails to recognize the death wish involving his mother as an effort to dissolve the incestuous attachment growing out of his Oedipus complex. He tells of having a heterosexual experience at the suggestion of a male friend who first had intercourse with the girl and whom he followed. Here he also fails to see the homosexual attachment, with the girl as the medium. At 4 years of age, he had his tonsils removed by a physician who later was his preceptor in his medical studies. He talks of compulsory ruminations and of various mania. In three acts of mania twelve years before, he was violent, and believes that it is a prelude to the present depressed turmoil. He asks, "How can all this be resistance?" If he feels more relaxed and can talk more at home, he reasons, why *not* have the analysis conducted there?

He further says, "Please cure all of these ills forever. If you can't death will, of course, try to succeed where analysis failed. I tried to give out emotional catharsis in my former analysis." He then relates many experiences he had as a patient in the various private hospitals where he was confined.

Dream 11:—The following day he relates a small dream fragment: "Someone asks me to eat nuts and bolts."

There is a double meaning to this dream fragment. Since eating is a coitus symbol, it represents his difficulty in making his heterosexual adjustment. There is also a deeper layer to this dream fragment concerning the digestibility of his analysis, the bolts being indigestible. He says that at 11 or 12 years of age he had a fracture of the skull and was unconscious. He received this injury at a camp. He admits telling his former psychotherapist many lies, as he feared he would make him increase his visits. He complains of insomnia and says that it became aggravated five or six months before. He remembers that insomnia was a prodromal symptom occurring usually before the attacks, whether they were depressed or manic in type. Earlier this spring he had an elated period following thoughts of marriage, although he had no girl.

These were all due to his day fantasies, verifying the general idea that in psychosis these patients expend a great deal of their libidinous urge in their minds.

SESSIONS 31 TO 40

In a following session many perverse ideas are liberated, a latent homosexuality being common in these cases. He talks of sodomy which he fantasied when he was 14 years old, usually as having relations with his mother's sister (incest). He was often told by his own patients that because their wives' vaginas were too large they wanted rectal intercourse. To him, the buttocks of women are appealing and exciting.

He has refrained from taking sedation, as he wants to get the drugs out of his system. He went to bed at 10 o'clock but had compulsive ruminations until 12 o'clock. He slept for an hour and then got up to eat cake. He then prayed for sleep and between two and four in the morning he had a hypnagogic hallucination. The content seemed to be vague but he remembers household furniture, glasses, milk bottles, silver bowls and the back of a woman marked with a target such as one sees in a shooting gallery. He also saw images too numerous to mention, some distortions and marks. He further says, "I then continued to pray for sleep and had more hypnagogic hallucinations. I seemed to be in frantic flight, running through a desolate mountain wilderness, along dangerous mountain ledges. I had conflicts between life and death and said 'What the hell—you have to die sometime.' I am sick, as you and I know, doctor. I am trying to tell you the truth, the whole truth and nothing but the truth. I was conscious of my unconsciousness at work, if such a thing is possible. Afterwards I was exhausted and had a psychogenic bursting headache and lethargy. I'm afraid a couple of nights like this would put me completely out of my mind."

Dream 12:—The next day he complains of exhaustion, attributing it to the material liberated in yesterday's session. He remembers a vague dream fragment in which he had a sexual experience with a woman of 40. She straddled him and told someone she had committed fellatio on him. He was later sorry that he did not "bugger" her (anal intercourse).

Dream 13:—He also relates this dream: "A girl comes to me and says, 'Don't kill yourself. My sister B. killed herself and didn't have to. I told her she had a peptic ulcer and could be cured.' She then entreats me not to kill myself. She was pretty and had a good build."

Both of these dreams represent wishes of the patient. The masked homosexuality is represented by his desire to have anal intercourse. The second dream shows his continual thoughts of suicide which dominate his mind.

On another day he is quite disturbed. He claims that

he had only three hours of sleep in one-hour periods. He brings up his former sexual problems. When he was 22, he and a friend played with a girl, resorting to mutual masturbation. He again spoke of the 40 year old woman who performed fellatio on him as having induced a psychic trauma on his personality and of whom he said, "She practically raped me." He tells of other experiences with girls but the sexual content seems to be only in his mind. In actual sexual play he never went beyond the preliminary stages. He mentions that all of his girl friends were telling him he was not the same, that he seemed to have changed.

His free associations go back to the age of 5, and he relates a coprophiliac experience with a little girl, also 5 years old, who defecated and pointed out the stool to him. He also remembers an experience when he and his brother performed anilingus upon each other. This experience is vague and he does not remember whether his sister was in it or not. He and his brother slept in the same bed until they were 5 years of age, and he remembers his mother referring to them as "good angels." He recalls his girl cousin whom he was fond of when he was 8 years old. From these recollections we can see that his heterosexual life goes far back into his childhood.

The next day in his free association his thoughts continued to be dominated by sexuality. He now claims that he was nearly 20 when he had his first heterosexual experience and that it was planned by a colleague. He then remembers having his first orgasm. He also confesses to being a compulsory masturbator and has practiced autoerotism once in four days since he was 20 years old. Even last night he masturbated and fantasied the woman of 40 whom he had formerly described as having raped him. He thought that by masturbating and using this fantasy he could eradicate this trauma which he believed she caused. He also tells of compulsions to indulge in *pseudologia fantastica*. He used to boast of his prowess as a boxer when at college and on many occasions claimed to have knocked men down with a single punch.

On another visit he again describes a hypnagogic hallucination. A screw was being turned in his brow. To this thought he associates prefrontal lobotomy, a method he has read of in the medical journals. He continues to talk of psychoanalysis and its results. He has a colleague who scoffs at it, but the patient now says that he is ignorant of its technique and knows nothing about it. To him it has been a great benefit and he believes that he has only matured lately as a

result of it. He digresses to his college life and to times before this when he first wore long pants. He remembers that his voice had not changed and he knew nothing of sex. He talks of his family physician whom he questioned about sex and who told him to forget it. It was shortly after this that his undescended testicle was brought down. He now believes that the peak of his depression has passed and he is making plans to resume practice. He claims that his suicidal thoughts have left him. His present zeal may be regarded as a sort of resistance and a calm before the storm.

SESSIONS 41 TO 50

During the next visit he says he is still restless and subject to states of panic and compulsory thinking, although his suicidal ideas are not active. He himself fears that they may be dormant.

Today he gives details of being hospitalized in a state institution for five or six months. In this place he says he was beaten and abused, and this episode comes up many times in the analysis. Each time he talks about it he gets irritated, disturbed and always threatens to take legal redress. Whenever he talks of this episode he talks of nothing else for the rest of the session. On another occasion he narrates his phobias. When a cab stops, he becomes panicky. He pleads with the analyst, "What can I do about it?" He describes rhyming thoughts, which are characteristic of this cyclic psychosis. "Deep in the heart of Texas, deep in the arms of neurosis." He speaks of his fear that he has a brain tumor. *Pseudologia fantastica* now appears, according to his confession. He would tell his classmates that he was working as a sports writer at night, trying to pay for his tuition. His mind comes back to sexuality, and he tells that he never had an ejaculation until he had his first intercourse.

Before ending the session he recalls two dream fragments:

Dream 14:—"There is a retired, gray-haired M.D. who helps me to establish a practice. Also I am visiting a psychiatric hospital."

His own interpretation of these two dream fragments is that they represent his present analysis and a former hospitalization. He continues to complain of weariness. All exercise tires him. He still has bad nights and has to resort to sedation. At times he fantasies his life at college, playing football. Also thoughts of his mother appear. Any thought of his mother disturbs him, and usually when she appears during an analytic period the session has to be terminated.

In another visit a new symptom appears: a tendency to repeat words (verbigeration).

He again talks of his interest in baseball and says he had to give this up when he began to wear glasses. He repeats his experience in receiving metrazol and electric shock therapy. During the visit he is in a very bad negative transference and cannot recall any dream material.

Two days later he relates this dream:

Dream 15:—"I am on a trip with my mother and we are sitting at a table. There is a large chute and a serpent is on it. Then a man introduces me to a group of girls. They are scrawny and want to call me a tribal name. They seem to want to "make" me. The setting was in some tropical place."

To this dream he associates a trip to Florida five years before, and in further free associations he brings out castration fears. He recalls that when he was 5 his mother asked him if he played with himself. There is an incestuous content in this dream. His trip with his mother represents motion, which is always significant of sexual activity. There is a transformation which takes place—first into a phallic symbol (serpent*) and later into a man in the company of scrawny girls. Since all dreams have a bisexual element, the dreamer here first senses the male element in his mother and later in the girls.

Dream 16:—On another day he relates some fragments of a dream in which both his mother and his brother appear. To this dream fragment he gives these associations: he once wanted to hang himself in his brother's house so that his mother would not get the shock which he dreads would take place should he commit suicide.

His fear of going mad suddenly first occurred about ten years before, and this has been persistent at times. He relates that his phobia of going to a barber shop began about the same time.

On another visit he tries to summarize his case. He confesses his fabrications to his former analyst and tells how disappointed he was in not deriving any benefits from his shock treatments. He now says that he has definitely made up his mind to cooperate in the treatment and to tell everything truthfully. He claims that he is better. His brother tells him that he laughs occasionally, something he has not

*According to Stekel, who is regarded as the most able dream interpreter, "the serpent may also be a female symbol, like all smooth, moist and slippery creatures. It may also represent the vulva." Stekel, Wilhelm: *Sex and Dreams*. Badger, Boston, 1922.

done in three years. He says his backaches have decreased, especially when riding in a cab.

It appeared that he was not improving but that he was going into an elated and hypomanic state. He still clings to his life and death drive. He fears to drive a car, as he may drive into a tree to make death appear to be an accident. His life and death urges also interchange. At times he wants to live, while at other times he wants to die. He tries to build up his physical state by exercise. He even tries to enlarge his palms by squeezing a rubber ball.

His inferiority noted in yesterday's session appears today when he relates this dream fragment: "I am sitting in a car and driving backward. At my side is the President of the United States. On my other side there is a cousin of the President." In free association he tells how he concocted numerous neurologic symptoms and was examined by two neurologists. He did this to evade seeing his former analyst. He then tells of a sexual episode which evidently was associated to his dream. At 14 he tried to finger a girl of 12. The girl threatened to call the police, so he became frightened and stopped. The President and the President's cousin represent his super-ego, and there is a thought of guilt in what he did when he was 14 years old.

He is somewhat resistant, as he came late to the session. He refuses to associate during the rest of the session but talks about his experience in a private sanatorium and the long psychoanalysis on a previous occasion.

The next day his negative transference continues. He again spends most of his time talking of his postgraduate work and his interest in physiotherapy. He says that he thinks a case of tuberculosis could be cured by this method of treatment. He also recalls a hypnagogic hallucination in which a man was slain with a needle. In this fantasy he believes the man is himself and that the slaying represents his suicidal attempts.

On another day his tirade against a former analyst continues, increasing his negative transference. He seems to be going into some psychotic exacerbation. He complains of feeling sleepy and fears he is developing a brain tumor. He wants to get a textbook and study the early symptoms of brain tumors. He admits that his thoughts of this new phobia keep him awake, and although he takes sedation, it has no effect on him. He gets up early in the morning and reads the papers but the thought of the brain tumor persists. He knows that feeling sleepy is an early sign of brain tumors. He is unable to recall any dreams. He is so wrapped up in himself that he continually seeks defects in any physical manifestation that he can think of. It is quite

apparent that sinister symptoms are being liberated and are emerging from his unconscious.

He claims that for thirteen years he was always able to secure sleep by autoerotic practices. Now, in the last three weeks he tries masturbation as a soporific but it has no effect. He says that formerly it worked like a miracle. He now talks of his "Jehovah complex" which he had in previous attacks. He thought that it had entirely evaporated.

On his next visit he complains of another new symptom—his fear of having sinking spells. He talks of various physicians and of special work which they do. He is thinking of taking up psychoanalysis himself and speaks of a famous internist who has a good knowledge of psychoanalysis. He says that his brain, which was lethargic during the past few weeks, is now becoming overactive. His production and speech are also accelerated and he appears to be in a definite hypomanic state. He speaks very rapidly, going over many things already enumerated. He stresses his relationship to his father and describes details of his death. His father believed in the hereafter, and the patient was solemn and in grief for a year after his father's death.

He now says his desires for masturbation have vanished completely and that he will never practice this habit again. When he first began masturbating, he used cold cream. Although he lacks a heterosexual urge, he says that he does not want to be asexual. Going back to early childhood, he recalls that his colored mammy said, "You smell so sweet." Religious conflicts are also apparent, and he says that for four days he has been saying daily prayers. He believes God created Freud and then sent the analyst to cure him. When his mother notices his praying, she pleads with him to cease it.

On his next visit his hypomanic state is increased and he seems to be going into a full-fledged manic excited phase. He talks rapidly and it is difficult to follow his spontaneity.

"Last night I only slept about one and one-half hours. During these long hours of seeking sleep I became certain of a life plan. More certain than I have ever been of anything before. I cannot tell you how I know because I don't know myself. But everything is going to be okay for me and you. This is all tied in with certain things I told you yesterday. (Evidently referring to God and Freud). I don't know when but after you have permanently cured me, I will be training under your direction, working with you and we will make out reasonably well. This feeling has nothing to do with Freud or psychiatry or analysis. It is not a father fixation nor a flight of a neurotic into psychiatry and analysis in a desperate effort to save himself. I cannot tell you more at this time, for I don't know what to say. I would rather you would not ask me any more about it at the present time.

However, at some time in the future, when and if you want to discuss all of this with me, I'll be glad to do so." (We can see the verbigeration.) He continues: "I do not know when you will have permanently cured me but I am more certain of these things than I have ever been of anything in my life with its periods of anxiety and crisis. I can make no guarantee. You must cure me permanently. I will co-operate 100 per cent."

His manic symptoms increase daily, and he shows more religious fervor and also shows other activity which is common in the manic states of manic depressive psychosis. He is overproductive and very voluble and is rearranging his office. He is in a state of euphoria and talks of marriage. At times he even shows some distractibility. He seeks to be purged of his guilt in relation to his father and mother. His thoughts are lascivious and he masturbates. He admits latent homosexual tendencies. He says he always wanted to have coitus in anum with women. He says he does not sleep, and he seems to be telling the truth for his eyes are very bloodshot. He says he has thrown all the sedatives down the lavatory. Although he is showing psychotic manifestations, he claims progress, thus displaying poor insight. He reads the Old and New Testaments. His spontaneity now is: "You opened my eyes. You wiped the ashes off. I am getting like a baby. I do not believe any more in an 'eye for an eye and a tooth for a tooth.' This week I got over the hump."

On his next visit his psychotic manifestations seem to be increasing in their activity. He shows oddities of conduct—such as smearing vaseline over cigarette butts, and he is so overactive that he has been placed in charge of a male nurse, as he seems to be going into an active psychotic episode. He now talks a great deal of Christ and says that at last he is cured. He says that Freud was inspired, but that now he is under a greater teacher than even Freud, Christ. He talks of God, repeating, "Love, animate and even inanimate".

He thinks his guilt for his Dad has been expiated and boasts that he is cured. He says: "I am feeling okay. Just tired. Will eat, sleep and rest for a few days. I do not need drugs. God is light—the true libido. They are all tied in with sexual tension. There are various automatic functions maintained for complete freedom from unconscious conflicts as we grow from babies to adults. For various reasons we do not see the light. Some never do. The kingdom of Heaven is—a little child shall lead them. Jesus. Now, do you understand?"

"I want to flow back to the complete security of our days at birth, surrounded by warm, soothing, maternal amniotic fluid, being automatically fed, which leads to various mental ills—for example, catatonic praecox, hebephrenic praecox, or a silly child."

He also talks of Moses and the Public Health Service. He shouts at the top of his voice: "I am now cured! The Golden Rule is Jesus—

the true God is electricity and power, radio, all modern comforts and conveniences!"

He is practically incoherent.

It is necessary to discontinue his psychoanalysis, and it is quite apparent that he is now in a state of psychosis. He refuses to leave his house, and the writer sees him there, where he stands playing phonograph records. He says that he is definitely cured and is through with all physicians. He runs around his office pointing to changes he has made, emphasizing that it was all due to anal eroticism. He says he had a hypnagogic hallucination, in which a screw was being bored into his brain. He shows a bottle opener. He says that he will not resort to lobotomy but will put the screw in the kitchen, where he can use it as a Coca-Cola opener.

He points to a shell and picks it up, saying; "What do you hear? You see, everything is libido—God—love." Pointing to his typewriter desk, he further says that he is going to write and does not want to practice medicine or gynecology. It is difficult to follow him. He shows many solutions and talks about time as "blue, trueblue whites, purity." He shows his adrenalin and tells that he had made four attempts at suicide. Then he points to his jock-strap and says he only masturbated once. He appears very elated and is in a definite manic attack. He points to a girl's picture on the wall (an actress) and says he will marry her.

Although he was so overactive and in a manic state yesterday, today he appears calm and collected. He wants to get a dog, buy a house in the country and live with his mother. He seems to be quite evasive, does not express any flight of ideas or distractibility and does not talk of religion.

Today is his last visit. Before coming to the office he sent a stethoscope by messenger, claiming that it had been used on Abraham Lincoln at his deathbed and had been given to him by an old physician. Today his manic symptoms have returned. He says he has been purged of everything and is entirely cured, but one symptom persists—his inability to sleep. He says he has made a new discovery and that is to analyze a patient in a continuous tub, which represents the amniotic fluid. He says that will give the patient a symbolism of blood. He wants his nurse discharged immediately, as he feels that he does not require anybody to look after him but he still considers himself under treatment. He also wants to consult his former psychiatrist, and later he does and tells him that he has found a bigger guy than himself—God, Jesus Christ—and that Christ is love.

During the afternoon he becomes overactive. He plays the radio and guitar. His pressure of speech is so voluble that it is difficult to follow his spontaneity. He jumps from one subject to another, his words almost rhymed. He says: "Libido is everywhere, in the ashes, rocks and air; nothing can be destroyed—I know everything:" At times he smiles but it appears to be euphoria and exhilaration. He says he

slept well and that he did not have to take anything but the Bible to bed. He then refuses to see any physician. He says. "Don't come here too often, I am very busy and will be for the next few weeks."

It was ascertained that he had purchased a crucifix, and his family became afraid that he might begin to preach religion on the streets. He was therefore committed to a mental hospital.

ANAMNESTIC RECONSTRUCTION

A 39 year old physician, who apparently has a clear heredity, has had four definite attacks of manic depressive psychosis, depressed type. There is a probability that he had many indefinite attacks which may have varied in duration and in atypical manic depressive symptomatology. Although some of his attacks were typically depressive in type, some may have been preceded by manic symptoms, like the attack just analyzed, which led to his final hospitalization.

Two of his known attacks were colored by many schizoid symptoms, the most characteristic being the "Jehovah complex," where he compared himself to Christ and reacted to visual hallucinations. The "Jesus Christ" complex is not rare and is often observed in hospital psychiatry. (The writer once had 6 patients in one ward of a state hospital each of whom claimed to be the Saviour. Many of them looked like Christ, having fine hair and features and being tall and slender in physique.)

This patient has a paranoid fear of being observed. He also has compulsory thoughts of suicide which have dominated all of his attacks. He made innumerable unsuccessful attempts to end his life, as has been observed in the history, finally succeeding in his last attempt.

His sexual problem is of paramount importance, for we can observe that it plays its role in precipitating his attacks. He is unable to attach his libido to the opposite sex. This is characteristic in schizophrénics, and they do not have to have actual contact or even extra-genital play. Sometimes even the thought of sex, love or marriage may precipitate a reaction. Even in his last attack we can observe that before the patient became excited he talked of marriage. In this connection he discusses various love affairs and sexual experiences but many of them are probably acts of fantasy rather than reality.

As we examine his dream life, we observe sixteen dreams, most of which were dream fragments. The dreams of the psychotic are the same type as those of the neurotic. If there is a great deal of regression in the psychotic, there will be more incoherence in the dream. In this patient there is a great deal of regression in his emotional and volitional field, but his intellectual field is not involved.

Dream No. 1 is a transference dream, as is usual even in neurotics. This is always important, as it indicates the degree of transference, whether it be negative or positive. To the psychoanalyst the dream is as the scalpel is to the surgeon. By the dream we gauge the conflict that is being liberated, and in the depressed psychotic if we liberate

unconscious conflicts too rapidly, it precipitates a state of panic, just as in surgery shock may occur if we prolong an operation.

His dream life showed a conflict of bisexuality and incest. The incestuous content may be observed in Dreams Nos. 2, 5, 6, 11, 14, 15 and 16. The others are indicative of transference and bisexuality.

DISCUSSION

At the beginning of the treatment the patient expresses good insight and realizes that he may be a schizophrenic. He is unable to differentiate between schizophrenia and manic depressive psychosis, but it often takes an expert psychiatrist many years of analysis to differentiate between these two diseases, which constitute the majority of hospital psychiatry. Years ago insight played a role in the prognosis of mental disease. Many a patient was allowed a parole from a mental hospital if he had insight. In schizophrenia, however, the patient may have no insight and still be regarded as in a state of remission, if his psychotic symptoms disappear. In manic depressive psychosis there have been numerous recoveries without any insight; while, on the other hand, some very dangerous psychotics have excellent insight. The term "insight" is a very arbitrary one and in modern psychiatry has little significance.

He estimates the time of the onset of his disease as eighteen years ago when he was a medical student. In his analysis, however, he often says he has had neurotic symptoms since childhood. He mentions having contemplated suicide even when he was a child, in case he should fail in examinations. It is not unusual in schizophrenia to observe prodromal symptoms as early as 5 years of age. Although the patient emphasizes the suicidal attempts, it is not uncommon to hear of psychotics and even neurotics speak of suicide. In fact, there is not a living adult who has never had a fleeting thought of suicide.

The four attacks seemed a great many to the patient but in hospital psychiatry one may encounter patients having fifteen or twenty attacks in a period of fifteen or twenty years. Remissions in manic depressive psychoses may occur at irregular intervals and recurrent attacks may vary from being several days to several years apart. It is possible to see remissions and exacerbations in a patient in even a single day.

The fear of being observed is a schizoid symptom. It shows his narcissism and his self importance. Schizoid patients often fear what other people are thinking about them. They cherish their narcissism and are perturbed about remarks that may be derogatory. The falsification in this patient's reporting of his dreams should not hinder us in ascertaining unconscious conflicts, because day dreams, night dreams and even manufactured ideas are all products of the unconscious.

Psychoanalysis is not the only medical procedure which has been ridiculed for a long time before being universally accepted. Jenner, like Freud, was also criticized for many decades for his work on vaccination. Physicians still ridicule psychoanalysis but recent advances

in psychosomatic medicine are gradually overcoming this resistance to so important a therapeutic practice.

While it is true that suicides have occurred during psychoanalysis, one must not ignore the fact that suicide can occur at any time and under any method of treatment. Psychoanalysis liberates homicidal and suicidal impulses, and during analysis these impulses have to be carefully watched. Since psychoanalysis is essentially an operation on the mind, the elimination of hostile impulses has to be controlled by analytic transference.

The patient's voluntary references to his sexual life show that it is one of his major conflicts, and most patients, without being questioned, like to discuss their sexual life early in analysis, since they realize it is of vital importance. Another point to note is that he remembers sexual traumas, as many neurotics and psychotic patients do, while normal people who have had similar traumas forget them entirely. He admits that an attempt at heterosexual love precipitated his nervousness, and all through the analysis of this case we will observe that attempts toward heterosexuality precipitated his excited and depressed states.

It is quite common to find neurotic symptoms in the psychoses. Phobias, compulsions and obsessional thinking are found both in schizophrenia and manic depressive psychoses. His agoraphobia, a common symptom in the psychoneuroses, has a deeper underlying meaning. His fear of going out is due to a delusional idea that he would be noticed and that anyone seeing him would recognize his mental aberrations. It is to protect his narcissism that he wants to hide from everyone.

Hyperacousis which he mistakenly labels the writing of words backwards, is actually the medical term for an inordinate acuteness of the sense of hearing. Among certain psychotic individuals, for example, patients in the manic phase of manic depressive psychosis, the special senses, such as hearing, sight and touch, may be particularly sensitive. Among others, especially those with a fearful reaction, the sense organs are unusually acute. (Hinsie and Shatzky. *Psychiatric Dictionary*.)

His masturbation fantasies are homosexual in character, although he may fantasy women. Whenever he attempted normal, heterosexual relations it always led to schizophrenic reactions. An inability to make a heterosexual adjustment has been long observed in all psychoses.

He cannot give any rational explanation as to why he has practiced sexuality only in his mind for the past nine years but it seems that his last experience, if we can believe him, was an act of fellatio which had been arranged by a friend of his and which precipitated a series of manic depressive attacks. (The writer has observed many patients in his analyses who developed psychotic reactions after perverse experiences of fellatio.) On further questioning he admits that he was impotent at the time and could not complete the sexual cycle. It seems that all of his attacks, whether they were manic or depressive in type, were precipitated by some kind of a sexual experience and even an

attempt at or a thought of it would cause hypomanic states.

All neurotics and psychotics who have a sexual inferiority are interested in the size of their penis. This patient was so concerned that he wrote to a medical journal asking for information on how he could enlarge the organ of one of his patients (actually himself). (The writer once had a patient who was so sexually inadequate that he maintained his phallus was $\frac{1}{4}$ inch in diameter and 1 inch long. He was a man of nearly 6 feet in height and there is no doubt that his phallus was of normal size.)

Narcistic individuals, and especially those with schizophrenic reactions, are also concerned with their physique. They all want to enlarge their musculature and chest development, and may enroll in correspondence courses to get results.

Castration fears appeared early in the analysis and he reported many instances in which he was sexually intimidated by his mother and father. At the age of 4 he remembers his mother questioning him about masturbation.

He once sought solace and security in death. Although he was cowardly and feared death, he had the compulsion to commit suicide. It is known that psychotics and neurotics who have an exaggerated fear of death and who are unable to resolve the conflict of life and death often commit suicide.

His sexual experiences related during the analysis had a latent homosexual element, frequently consisting of extra-genital play; and even in these infantilisms they caused schizophrenic reactions.

Sadism and masochism also loomed large in his libido; the sadistic acts during adolescence and his masochistic behavior during his psychotic episodes showed an emotional inadequacy. As in all psychotic mechanisms, the bisexual element was present; the latent homosexuality had decreased the heterosexual urge, which had occurred sporadically only to be overwhelmed by his narcissism, latent homosexuality and perversions. These emotional conflicts prevented him from attaching his libido to women.

The incest barrier, too, was present in his dreams, free associations and in his Oedipus complex, and it was this incest complex that finally overwhelmed him and precipitated suicide.

Although he finally succeeded in his last attempt at suicide, his previous attempts may be regarded as masochistic in character, a punishment for the guilt which was present in his daily life and which could not be dissolved. As the analysis progressed, more conflicts were liberated and his Jehovah complex led to his last manic phase which precipitated his final hospitalization.

The spontaneity recorded in the final pages of his history shows that he developed schizoid symptoms, increased psychomotor activity, distractibility, rhyming, increased volubility, euphoria and manic excitement.

1900 F. ST. NORTHWEST

SCOPTOPHILIA—EXHIBITIONISM: A CASE REPORT

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I. INTRODUCTION

Exhibitionism may be defined as a form of sexual gratification derived from the exposure, in public, of one's sexual organs in the presence of another person, usually of the opposite sex.

Scopophilia, literally translated as the "love of seeing," refers to an anomaly of sexual life in which the person obtains pleasure from looking at that which is capable of producing in him a state of erotic stimulation.

A recent review of the literature on exhibitionism revealed only 1 other case in which pathologic scopophilia constituted the paramount symptom that paralleled the patient's compulsive urge to exhibit himself. In view of this fact, there would seem to be justification for presenting this particular case in order to demonstrate the inter-relationship between exhibitionism and scopophilia. An attempt was also made to bring to the surface the psychic mechanisms responsible for the patient's sexual behavior.

While exhibitionism may no longer be regarded as a psychologic enigma, thanks to the contributions of Kraft Ebing, Stekel, Ellis, Bloch, Karpman and others, a thorough understanding of its underlying psy-

chopathology still remains a challenge. There are many aspects of this problem which still need to be interpreted in the light of our newer knowledge of psychodynamics. Contrary to lay opinion, a good many exhibitionists who come into conflict with the law, are well educated and hold responsible positions in their community.

According to recent statistics, exhibitionism is one of the most common of all sex offenses. Perhaps this is true because exhibitionistic and scopophilic tendencies are normally found in everyone. The interest which many persons show in pornographic pictures may be regarded as an attenuated form of pathologic scopophilia. Pathologic exhibitionism, as we all know, manifests itself only when there exists an early neurosis of psychosexual origin, as we shall point out in the following case report.

II. THE CASE. MAIN FACTS

The patient is a white male, aged 41, born in Kentucky, married for the second time, having been divorced from his first wife in 1932, a printer by vocation but who devotes a great part of his time to conducting a church orchestra and chorus. He has 2 daughters, ages 19 and 17, by his first wife and a 10 year old daughter by his second wife. He considers himself quite religious and is an active member of his church. He attended a State Normal School, following graduation from high school, and took various courses extending over a period of three years at one of the local universities.

In April 1945, he sought psychiatric treatment, after having been arrested on several occasions for impulsively exposing himself before members of the opposite sex. He remained under treatment from April 1945, to Dec. 3, 1945, a period of approximately eight months. He had only about thirty sessions of analysis, as he was irregular in his attendance and manifested considerable resistance to treatment.

His wife claims that he made a satisfactory adjustment to the extent that the urge to exhibit himself disappeared. Two years later (1947), however, his wife called me to inform me that her husband had been picked up by the police for exposing himself and was being detained at the local mental hospital. He was referred for treatment to another psychiatrist. There is no information on hand relative to the patient's response to subsequent treatment.

III. HISTORY OF PRESENT ILLNESS

Patient expressed his complaint-problem during the first interview as follows:

"I have a desire to expose myself. I get a thrill out of it. I also like to see a couple engaging in sexual intercourse. I have looked in windows and have seen people having sex relations. I sometimes masturbate at the time. Once I saw 2 girls in bed fondling each other's sex parts. It was at a rooming house and I was parked in my car where I could see. It

gave me an erection when I saw them kiss each other. Afterwards I had many fantasies of this scene and masturbated frequently. That was in 1943. A year later, in 1944, from the window of my room where I worked I saw a young couple having intercourse. Another time I saw a woman undress and walk around in the nude. In 1945, I looked through a window and saw a woman masturbating by rubbing her sex parts with her hand while reading. I worked opposite a hotel and had many opportunities of seeing all kinds of things including perverted sex acts. In one instance a man put his mouth to the woman's sex parts. I used a boy-scout telescope."

Patient apparently conditioned himself to scopophilic gratifications. We know that scopophilia and exhibitionism are sister-paraphilias in the sense that they are psychogenically interrelated. The two sometimes go together.

He claims that the onset of his scopophilia began a year after his second marriage, 1934, at which time he developed the desire to "look." He states:

"I wasn't getting any sex satisfaction from my wife. After the baby was born she became frigid. I attributed my abnormality to a desire for more gratification, until it had an influence on me."

His first arrest occurred in 1934, shortly after marrying his second wife. He received a suspended sentence after paying a forty-dollar fine. Regarding this incident, he tells us:

"I was in my car which was parked, looking at a woman in an apartment house. It was daytime. I took my penis out. After a while a police car pulled up. The complaint was made by the woman in the apartment house, who turned out to be the wife of a dentist."

His second arrest took place in April 1945 (eleven years later), just prior to his seeking psychiatric treatment. This time he was sitting in his car and did not expose himself. Instead, he claims he put his hand to his sex parts and attracted the attention of several girls, who reported him to the police. They referred him to the sex squad. He was booked for investigation and had to appear in a line-up before a group of policemen. The police had been told that the patient had exposed his penis. The charge was disorderly conduct. There was no prosecution. His wife spoke to the Lieutenant and it was agreed that he should see a psychiatrist. He started treatment shortly afterwards (April 1945).

III. FAMILY BACKGROUND

1. GRANDPARENTS:—Patient claims that his maternal and paternal grandparents are of English, Scotch and Irish descent. They

were born in the United States and he knows nothing more about them except to say that they enjoyed good health.

2. **PARENTS:**—A. *Father:*—Living and well at the age of 76. He retired as a minister and is described by the patient as being dignified, having no vices, a strict vegetarian, rather serious minded and stern. Patient claims he was never very close to his father. B. *Mother:*—Living, age 70; complained of ailments most of her life. At one time she thought she had cancer. Suffered from hysterical attacks accompanied by screaming. Members of the family would rub her arms in an attempt to calm her. Talented in music.

3. **SIBLINGS:**—Patient is one of 4 children. Oldest brother is 44, married and in good health. The brother closest to patient's age, 38, is also married but is described as being nervous and suffers from stomach trouble. The youngest brother, age 32, is married and apparently in good health.

4. **PARENTAL STATUS:**—According to the patient, his mother and father never got along well. He attributes their incompatibility to his mother's neurotic make-up, stating that she dominates his father and does most of the quarreling.

A. *Relationship to Mother:*—Patient evidently was inspired to study music by his mother, who plays the piano, organ and violin and has taught music. Regarding his mother's hysterical make-up, he claims she would scream and that, on occasions, she has rolled over on the lawn of their home because she couldn't stand to hear her other son quarrel with his wife. She was accustomed to preach to her children, being very religious, and told the patient he should be prepared to meet his God. She once threatened she would do herself bodily harm if ever the patient had to be committed to a mental institution.

In the course of one of his free-association sessions he recalls having said to his mother, "You never got enough love in your life. That is your trouble." She replied that she could have gotten any number of men. She was afraid of electric storms and would take the children in the cellar and pray for protection against lightning. Patient claims that up to the age of 10 he was fearful of the dark. He would imagine lions and gorillas coming after him. His mother would come to his bed and hold his hand. He also was afraid some "hideous" man would attack him. He still is afraid of the dark.

B. *Relationship to Daughters:*—Patient expresses a deep devotion for his daughters (by previous marriage). In one of his letters to one of them, he states:

"I desired strongly to contribute more to your training, schooling, spiritual and physical welfare, and in return to have the joy of your youthful companionship and the sharing of your problems and interests. But I seem to have failed and would like to know just how and why from your standpoint."

He complains about his other daughter not having written to him in two years. Evidently he feels guilty, as his letters have a masochistic tone to them.

In another section of the same letter he goes on to say:

"I thank God for my daughters, and pray every day for their spiritual and physical welfare. But I can't help but feel there is a deep chasm between us that I wish were not there."

IV. PERSONAL HISTORY

1. **CHILDHOOD AND EARLY HOME ENVIRONMENT:**—Patient spent his early childhood in Louisville, Ky. He remembers how he was whipped many times by his mother, whom he had previously described as "neurotic" and "very excitable." He recalls how he once fell off a horse at the age of 10 and that he was unconscious, resulting in chronic headaches afterwards. Many neurotic patients tend to attribute their difficulties to some injury or accident in childhood, in an effort to sidetrack their own responsibility for their delinquent behavior. His eyes were crossed as a child, necessitating the wearing of glasses, which most children despise as it enhances their feelings of inferiority. The home environment was apparently a neurotic one, for we are told that the patient's brother, at the age of 13, ran away from home because of being whipped. There was an atmosphere of constant unhappiness. At the age of 15, his older brother teased him with a toy gun and pretended to shoot him. His mother became frightened and scolded them for it. She was always afraid the children would get hurt.

2. **HEALTH:**—Patient had whooping cough, diphtheria and measles as a child. At the age of 10, he contracted malaria. During that same year he had a tonsillectomy. In 1929 he had gonorrhea. Six years ago he developed pneumonia and about that time also his "stomach trouble" was diagnosed as a duodenal ulcer.

3. **EDUCATION:**—There is no indication of any school difficulties. He graduated from high school, attended a State Normal School and took various courses at college but without ever getting a degree.

4. **RELIGION:**—Patient attends church which he claims teaches temperance in all things, eating, drinking and sex relations. He was taught to abstain from drinking tea and coffee and brought up to believe that meat is not only unhealthful but prohibited by the Bible. However, he admits eating meat at various times but does not let anyone know about it. He considers himself a hypocrite and believes that exposing his genitals in public is a sin.

5. **PERSONALITY MAKE-UP:**—In evaluating himself, he states he has a number of faults which he would like to overcome, such as: (1) a desire to excite women's passions; (2) habit of smoking; (3) habit of staying up late at night; (4) procrastination of work that should be done; (5) morose moods; (6) a tendency to neglect his health by too

many outside activities; (7) an indifference toward responsibilities; (8) indulging in pleasures contrary to religious teachings.

V. SEX LIFE

1. **EARLY SEXUAL RECOLLECTIONS:**—Patient states that at the age of 5 he would get down on his hands and knees with his "privates" exposed and pretend he was a cow waiting for someone to milk him. He was preoccupied with various sexual fantasies in the early years of his childhood. For instance, he imagined a girl would sit on a toilet seat and "something long" would penetrate her sex parts. He remembers a little girl who would bring her dog into the toilet with her. The rumor circulated among the children that she would attempt to induce the dog to have intercourse with her.

2. **MASTURBATION:**—At the age of 13, he masturbated for the first time resulting in an emission. Prior to that time he fondled his sex parts (manustupration).

3. **SEXUAL FANTASIES:**—He describes his sexual fantasies, which are of a paraphiliac nature, as follows:

"Fantasies have included such scenes as lesbian lovers—aroused sometimes by the reading of low-grade (obscene) literature; pictures; and just observing women in apartments undressing together, etc.

"Imaginations of giving nudist parties where all guests shed all clothing upon arrival and free-love was carried on all around the place. Or attending such orgies in other places where one large room was magnificently furnished with deep rugs and heavy tapestries, dim lighting and music accompanying all sorts of fantastic love making by couples on floor, chairs, etc.

"Just seeing a male dog with large and obtrusive sex parts brings to mind experiences I have read about and heard told about women using dogs for sex gratification. Picturing in my mind how they might go about such experiences and bringing on a desire to witness such a procedure.

"When entering a newly rented room, I found in the closet on a shelf a stick one end of which had been wound with a rag and a "rubber" slipped over it making it a fair substitute for a man's penis. It caused me to imagine just how the user might have gotten a lot of gratification out of it—and the thought would arouse me. Also saw at one time a tallow replica of a man's organ which aroused fantasies of its use by a woman.

"Never witnessed a movie of the type shown at smokers, of sexual episodes, but have imagined what they would be like and have desired to see them—just never had the opportunity."

One can appreciate from these descriptions his imaginative leanings—the desire to see many couples in the nude (a wish to see once again his parents having intercourse); to witness lesbian orgies (masked homosexuality); to witness scenes of bestiality involving women (masochistic identification with the animal).

4. **PSYCHIC TRAUMA:**—Patient admitted to his wife that as a young boy he once witnessed his parents having sexual relations. This occurred when he was 10 years of age. Regarding this incident he states:

“My mother and father were in bed together. They were covered with a sheet. He was on top. In later years I understood what had happened.”

5. **EXTRA MARITAL RELATIONS:**—He merely admits having committed adultery several times during both marriages. In each case, the woman was married at the time.

6. **SEX-EDUCATION:**—He was brought up to believe that people indulged in sex relations only for the purpose of procreation. When he married, he asked his mother if it was proper to have intercourse for the pleasure of it and how frequently one should engage in sex relations with his wife. This discussion between an adult son and his mother in which the son confides in the mother his sexual problems is perhaps suggestive of the element of a repressed incestuous relationship between them. His dependency upon his mother for advice revealed the extent of his emotional immaturity.

He makes a rather significant statement: “I did not have a sister and hence I did not know at the age of 19 how a woman was constructed sexually.” It is significant insofar as it is suggestive of his having entertained incestuous fantasies involving an imaginary sister. He also states: “I had never kissed a girl as I was brought up to think it was wrong.”

When he was 9 years of age, his mother told him how babies were born. She told him babies came out of her stomach, and would make the patient feel her abdomen for fetal movements during occasions of pregnancy. He was told by his mother not to get into buggies or cars and she warned him that strange men would stick something like the end of a broomstick into his bottom and that he should also stay away from girls.

7. **HETEROSEXUALITY:**—A. *Relationship to First Wife:*—Patient states that his first wife once informed him that some fellow had seduced her and that she was not a virgin. However, patient attributes this to her imagination as he feels she was always too naive for it to have happened (wishful thinking—a fantasy of wanting to have married a virgin, mother-surrogate). He admits pre-marital sex relations with her, at the age of 19. She was 17 years old then. Patient took the initiative. He resorted to withdrawal intercourse as he had no contraceptive most of the time. Patient states that during sex relations she

would get very passionate as though she "wanted to jump out of a window." They had intercourse frequently and in 1924 he married her. She was the first girl he had ever kissed. His first wife once caught him with another woman and attempted suicide as a result of it. The situation resulted in a divorce.

B. Relationship to Second Wife:—Patient states that he indulged in premarital sex relations with his second wife before he was divorced from his first wife. She became pregnant and subjected herself to an abortion (1936). It was a three-months fetus. He was finally divorced in August 1943, and remarried that same year. He discovered that his wife could only achieve an orgasm if he manipulated her clitoris with his hand. Sometimes it would require thirty to forty-five minutes for her to reach a climax in this way.

His second wife was a close friend of his first wife. They both worked in a beauty shop and remained friends even though they competed for the patient's love. He claims his second wife lived within a self-built wall and at one time had to rest in a sanitarium where she was under the care of a psychiatrist. She is described as lacking initiative, inclined to be passive. Her mother divorced and remarried. Patient claims also that she was overattentive to her mother, who tried to influence her never to marry. He also states that his wife once told him no man was ever good enough for her. She complained frequently that the patient was married to his love for music. He describes her as being jealous and somewhat neurotic, stating that she had nothing to do with her father, who drank to excess. Her parents were finally divorced. He claims that "China Sky" (a movie) depicts his wife's attitude toward his work and his associates.

His wife complained that the patient would neglect his appearance and failed to keep himself clean. She preferred to have him take a bath before intercourse (a requirement common to many frigid wives). His wife excused her lack of interest in sex by blaming it on a post-operative incisional hernia. He finds that he gets no satisfaction from kissing her because she does not reciprocate. Occasionally the sex relations are satisfactory and she admits having had an orgasm. However, most of the time he has to gratify her by manual manipulation of her clitoris. She objects to his using contraceptives.

In an interview with patient's wife she related the following information. Apparently it is accurate and reliable, as the patient later admitted that the things mentioned about his mother were true.

"According to my husband's mother, every girl is a hussy. There just aren't any good girls. She told me she didn't allow her husband (patient's father) to touch her sexually for 15 years; that he didn't deserve it because he was cruel. She confided this to her son (the patient). She goes into fits of hysteria, locks herself in a room. Many times the father had to call his son to come to the rescue. She still has

these spells. The patient's father is a very religious man. He's hen-pecked. His mother's mind is always in the gutter (referring to the patient's mother). She sees sex in everything. In fact, I think she is over-sexed. She is suspicious and thinks every woman is making overtures to her son. Many times when I crossed my legs she would tell me to pull my dress down over my knees. I believe she has always been possessive. She still makes my husband sit on her lap, rocks him, pets him and kisses him, calling him her baby. He simply smiles and accuses me of being jealous of his mother. It's repulsive to see a mother carry on with a married son the way she does. My husband's parents don't eat together. The father cooks his own food. They are vegetarians.

"My husband's mother once asked my older daughter if she was ever touched by boys. She asked my youngest daughter when she was 5 years old if a boy had ever crawled up on top of her and put his "thing" into her."

There is no reason to believe that the wife would volunteer such information if it were not reliable. It would seem, therefore, that the patient's mother is highly neurotic.

The following reveals the existence of apparent psychosexual pathology in the patient's mother, judging from the wife's account of past experiences.

"My husband's mother peeps in windows. She runs a tourist home. She was once caught peeping in key holes and the people were going to report her to the police. Because my husband's father is a minister they hushed it to prevent a scandal. Once she called me into a dark room to have me look across the way at a man who was in the nude having intercourse with his wife. I told my husband about it and he told me his mother gets a kick out of watching couples engage in sex relations. On several occasions she caught her son peeping and shared with him voyeuristic gratifications."

In one of his sessions, patient related the following account of his feelings toward his wife.

"My wife was brought up to abhor sex. She said her mother would never undress in front of her father. She was the same way. If I approached my wife from behind she would cool off. She said it reminded her of dogs. She once permitted rectal intercourse. She would object to my using a new position like intercourse on a chair or standing up.

"She said she did not like to touch my penis because she is particular about cleanliness. She mentions frequently about my smelling of perspiration during intercourse. She wants me to take a bath before sex relations. We're not as close as we should be. There is a wall between us. I felt it was

more important for her to get sexual enjoyment than myself."

Further information regarding patient's relationship to his wife is revealed in a letter addressed to his analyst during a temporary interruption of his treatment.

"Dear Doctor:

"My visits to you I know have helped me in general ways. But I could continue taking your treatment for years without it doing my wife one bit of good and therefore not remedying our problems. I have tried to explain the disturbing factors as best I could, with frankness and as little bias as I could because I was in hopes you could find the solution in these statements of feelings and resentments. And I have felt sure that I love my wife enough to want to remedy the situation and hold the family together.

"I know that I haven't been much of a husband of recent years and maybe I'm so conditioned as to be impossible to make any woman a good husband now. But at least I know in my heart that I have always been willing to admit my faults to her and to make amends for everything disturbing—when or until any little thing comes up that causes the same old atmosphere to bring all good intentions into disrepute.

"Perhaps the only solution is separation—but, hope has never completely died in my breast—that she might through love of fellowman and of God, change and become tolerant of one's frailties or weaknesses. I just can't seem to be reconciled. It might be that a separation for a time might bring about some changes. Do you think so?

"I admit to you and to her that I have a lot of bad habits, but nothing that real love manifested would not overcome, I feel sure.

"She makes demands of me; claiming her rights—and I'm sure you know what reactions that gets in any red blooded man, unless he is born a milquetoast.

"I never did, and doubt if I ever will believe that love makes demands. Except—let me add quickly—in such a subtle manner that they are not demands but needs and desires that arouse the one loved, to want to fulfill those needs and desires.

"This is probably pretty much confused as to reasoning and style as I am typing it under stress of hurry at the office and I hope you will excuse the lack of continuity.

Sincerely,"

In one session he began enumerating the things he liked and disliked about his wife. He claimed she was an excellent cook and a good housekeeper—that she had beautiful hair, wore attractive clothes, had a shapely figure, was intelligent, honest and highly moral. On the

negative side he observed that she was intolerant and critical, failed to show enthusiasm, was inclined to be too reserved, not socially inclined, defensive in the presence of strangers and not particularly interested in music.

8. *PARAPHILIAS*:—A. *Bestiality*:—At the age of 15 he had sex relations with a cow and a mare. This was accompanied by strong feelings of guilt, as he was afraid of being caught in the act. It occurred about five times over a period of about three years. He would go into the barn and stand on a stool. One time his father suspected something wrong and in his son's presence lifted the cow's tail. Patient remembers the tremendous guilt he experienced. He states that he would have an emission in the mare's vagina. At first he would put the handle of a buggy whip within the vagina which would make the mare raise her tail. He also attempted to have sex relations with a chicken when he was 13 years old and thought he had injured the foreskin of his penis after an unsuccessful attempt at penetration. At the age of 14 he witnessed a cow and a bull having intercourse.

B. *Exhibitionism*:—Regarding his predominant paraphilia he states:

"I have no desire to exhibit myself for the sake of showing my sex parts but only get satisfaction if a woman is stimulated by it." (a psychic substitute for his repressed incestuous desires).

He states that since treatment he has had no desire to walk around in the nude at home, or fondle his penis in his wife's presence (activities that he had indulged in prior to analysis).

He generally exposes his penis in a state of erection and gets excited at the thought of subjecting innocent girls to this indignity. However, he does not always prefer young women or children for he has often exposed himself before middle-aged women (mother surrogates). He claims that the impulse to expose himself is sudden and irresistible. He knows he has done wrong and regrets it each time, having fought against it in vain. The exposure is usually carried out during one of his stuporous or pathologic dream-states.

C. *Scoptophilia*:—During the course of treatment he tells us that his desire to indulge in peeping into bedroom windows has stopped—that he had many opportunities but did not take advantage of them. Prior to analysis he engaged in numerous voyeuristic activities. He would look into parked cars. Once he saw a woman age 35 walking about her apartment in the nude. He enjoyed seeing her breasts most of all. During the summer he would frequent parks and has at times seen couples engaged in sex relations while lying on the grass. At the age of 8 he saw his mother's breasts while she was nursing the youngest child. Once he walked into the bathroom and saw her take a sponge bath.

He claims "looking" became a habit rather than an impulse. On

one occasion he witnessed two women indulging in mutual cunnilingus. He has always been interested in voluptuous breasts (partialism) and likes to "suck" them. Patient brought home to his wife several pamphlets illustrated with pornographic pictures of persons engaged in various perversions, with the hope of arousing her sexually. He claims they had no effect on her. She was still frigid.

He once brought an essay which he wrote entitled "Revelations and Confessions of a Voyeur" in which he described a few of his own voyeuristic experiences. It reads as follows:

"Little is known by the great majority of human beings just how frightfully prevalent is the sordidness of man's life in the twentieth century. The average man and woman—fortunately the greatest number of men and women constituting the race—get up in the morning, go to work, come home in the afternoon, and spend the evening in reading, visiting with friends, or pursuing some healthful recreation or pastime until bedtime starts the cycle all over again.

"Only those who have practiced such a 'Dr. Jekyll and Mr. Hyde' existence can fully realize the extent of base passions and degrading practices of the human race.

"In the narrations which follow I will attempt to portray some observations of episodes and impressions that I have experienced.

"Soon after my second child was born, I moved my family to an apartment which was on the third floor of a private dwelling, the back window of which faced an apartment house on the next street.

"We had not lived there long until I became curious in watching those apartment house windows at night, because so many of the people would fail to pull their shades down and the thought of peeping in on their private lives, as it were, was intriguing to me.

"It was not long until I observed in one of the apartments that a man and a woman who were obviously not married would carry on their love trysts without shielding themselves from the eyes of those who lived across the way, perhaps because they thought the distance too far for observation.

"Several evenings I watched as they would pet passionately and finally go into the bedroom and take off their clothes. The bed was almost out of sight completely, but I would stand and become highly aroused at the imaginations of what they were going through on the bed.

"And one night the man seated himself on a straight chair and the woman came up in front of him and pulled her skirt up and straddled him facing him and sat down on his lap. They proceeded to love in that position for some time

and as well as I could make out from a distance, they were having intercourse that way.

"A little later when my wife and I had been separated for some time, and the children had been left with their grandparents, we determined to try living together again, and so moved into a rooming house near our work and ate our meals out.

"My curiosity into the private affairs of other people had been aroused to the extent that I would peep through the cracks in the single wall partition between the bathroom of the rooming house and the bedroom in which lived another couple. However, I could see very little, but would hold my ear close to the cracks in order to hear their conversation and noises of love-making, imagining all sorts of erotic things that would excite me, and make my heart pound with anticipation.

"Across the hall from our room there lived another couple, and on several occasions when I knew they were in, I would quietly open the door to our room and tip-toe across the hall to their door and peep into the keyhole. The bed was in full sight of the keyhole and one time they were having intercourse with the woman on her hands and knees astraddle of the man on his back. As she moved up and down on the man's penis I could see the genitals very plainly and was highly aroused at the sight, watching until she asked him, 'Are you ready to come.' He answered, 'Uh huh.' As the climax came, I hurriedly arose and sneaked back to my room and carefully closed the door. Always on the alert for footsteps at the bottom of the stairs or someone coming downstairs from the next floor but was never caught in that predicament while snooping there.

"These episodes took place when my wife was absent from the room as she was working more steadily than I was at the time, and I had quite a bit of idle time on my hands."

VII. DREAM-LIFE

1. EXHIBITION AND PENIS—NARCISM DREAM.

"I was showing some friend my violin. I was proud of it. I was elated over it. I refinished it."

The dream reveals patient's exhibitionistic urges, his penis disguised as a violin (phallic symbolism). There is also evidence of penis-narcissism (being "proud" of his penis). Having "refinished" his violin may symbolize masturbation following exposure.

2. SCOPTOPHILIA AND UROLAGNIA DREAM.

"My wife, daughter and myself were riding in a jeep. My wife wanted to urinate so I stopped along a ravine and told her to go there. I parked along the bank. Some military police came along in a jeep rounding up drunken soldiers.

The bank gave way and their jeep landed at the bottom of the bank. However a couple of men picked up the jeep and put it back on the road again."

In his associations to this dream he informs us:

"Once I saw a woman jump out of a car, and squat near a tree to urinate. It was winter time. I was driving my car, slowed down but did not stop. I could see her buttocks.

"My wife often comes into the bathroom to urinate occasionally when I'm shaving. We leave the bathroom door open if our daughter isn't around."

There is some suggestion of urolagniac and scotophilic pleasure in watching his wife urinate. His wife in the dream may also be himself (identification). He uses the need to urinate as an excuse for exposing himself. Being left alone with his daughter in the jeep may be associated with certain repressed desires as corroborated in the anamnesis. The military police portray the id-super ego conflict resulting in a triumph of the id (the jeep of the military police lands at the bottom after the bank gives way. "Rounding up drunken soldiers" denotes his anxiety regarding being picked up by the police [fear of father punishment]). The word "drunken" suggests the idea of not being mentally responsible. The fact that the men fall at the bottom of the bank where his wife is urinating also betrays his latent homosexuality at the fantasy level (having military police see his wife exposed—projection of his own exhibitionistic and scotophilic tendencies).

3. DEATH-WISH DREAM.

"I had frozen to death."

This may be a wishfulfilling dream depicting his desire for the death of his abnormal sex life.

4. ANXIETY DREAM.

"I dreamt of torn down buildings."

Denotes anxiety regarding his shattered life—his dissolved first marriage—the possible ruin of his reputation in his community.

5. EMBARRASSMENT DREAM.

"I was walking with a young lady. She was having difficulty with her husband or some man. Either she was dressed in a bathing suit or put one on. She was about to go in the creek. Two young fellows came along. She tried to hide in the water. One fellow said, 'What is that, a mud turtle?' I tried to lead the man away."

The eroticism of a woman embarrassed because of being seen in the nude is evident in the dream. The head of a turtle protruding from the shell could very well have reference to the woman's clitoris.

6. ECHO DREAM.

"I dream of houses and couples. There was some sex angle."

There is obviously an amnesia to advantage (resistance) for the details of what took place. However, we can say that it probably is an

echo dream of previous experiences in which the patient would look through windows to watch couples engaged in intercourse.

7. FATHER-IDENTIFICATION DREAM.

"My father and I were riding along a high road in a buggy in the road but left enough room for the cars, and we passed on by. Then we came to another barrier with still enough room to pass on by; and there was a side road at this point that led off to the left to a road higher up. Some cars went on through the narrow space at the side of the barrier and we drove on, too. However, not far away we came to an abrupt end of the road with a barrier fence across it. It seems that cars had turned around at this point and gone back, but I noticed a short span leading off to the left that had connected with the road above and was not cut away from it by a short steep bank. After ascending for a moment I was sure that the horse could negotiate the bank and pull the buggy up so that we wouldn't have to go back. But after climbing up myself and looking down I was dubious and called back to my father that I thought we shouldn't impose that on the horse but should go back to the turnoff and we agreed. But I recall feeling very much put out because the workmen had not closed off this part of the road and put a good sized detour sign up."

This dream depicts his relationship to his father—an attempt to overcome the emotional barriers that existed between them (identification with the father); the barrier represents their difficulty with women, common to both of them.

8. INCESTUOUS DREAM.

"My youngest daughter was strolling along a dirt road that went by my brother's barnyard. There was a cobble stone wall along the barnyard and something like a wire or rope protruding from it. I caught hold of it and worked it out of the cobblestones. And when I placed them in position a stream of spring water seemed to burst forth just below. It seemed there had been a spring there before as there was preparation for a little water fall and culvert. But I thought of it coming from a barnyard and that it couldn't be good for use, so I worked a little more on it and stopped the flow. However, it seemed it was pushing the wall out so I cautioned my daughter to stand around from in front of it so that if it did burst she wouldn't get hurt. I also stood and watched from the side but, although it bulged, it seemed it was going to hold."

The dream suggests an attempt to repress his incestuous desires involving his daughter. "Although it bulged it seemed it was going to hold" is a symbolic expression of repression. The fear that his daugh-

ter would get hurt represents his anxiety should he fail to hold back the stream of water (his ejaculation).

9. WISHPFULFILLING DREAM.

"My wife and I were lying around on the grass with other girls and our daughter. My sex desires were strong and confused. However, it seemed others left and we were lying on separate beds in the house, and when I noticed no one else was around I moved over into her bed. She turned over toward me and seemed acceptable to the advance, but when we were close together and I had an erection, she accidentally moved her hand past the end of my penis in such a way as to get lubricant moisture on her fingers and raised it up and said 'Now—look what you've done.' I said, 'Well that's only natural.' Then some girls were coming into the house so I slid back into my bed. My wife got up and was dressing. I was going to shave and my daughter had my straight razor out of the case and I hurriedly took it from her hand and she said I had cut her. I noticed a little scratch. In the meantime, my wife had started to shave with a safety razor and I asked her if she didn't want me to shave her, but I believe she said she could finish with the safety—and the dream faded."

Here again we have suspicious evidence of his repressed incestuous thoughts involving his daughter (sex desire was strong as he was lying on the grass with his wife and daughter). Having his wife touch his penis is wishful, as this was something she generally did not do. Cutting his daughter with a razor may symbolize his subjecting her to a psychic trauma of some kind; wanting to shave his wife is also wishful (a paraphiliac desire to shave her pubic hair).

10. COPROPHILIA DREAM.

"Was helping undertaker handle the body of my uncle, or someone I had known. When we started to take the body up, he stopped and found a couple of sticks and started after something around the body and I came closer to see what he was doing and found he was trying to get hold of a piece of fecal matter that had passed from the body. He made several attempts before he managed to get it and put it away somewhere. Then we went ahead with moving the body into a box or coffin."

There is an obvious suggestion of coprophiliac interests as well as a preoccupation with the theme of death in the above dream.

11. DISPLACEMENT OF GUILT DREAM.

"I was sick in a hospital and my wife was sick in bed. I too was ill, but was up and at least partially dressed, when a doctor who was in my Arlington choir came out of an adjoining room and was saying something about that patient

having some dread malady. He went over to the bed and examined my wife, but then left without my finding out what his diagnosis was. I called after him but when he didn't come back, I slipped my robe off and hurried out to find him, thinking that he hadn't told me what was wrong and I feared it was the malady he mentioned. I went outside and noticed the spacious well-kept grounds and buildings—searching for him but didn't find him and the dream faded."

In this dream he projects his own malady (exhibitionism) on to his wife by making the wife the patient of the analyst. It may also have reference to her frigidity and he wants to be told by the analyst that she is the one who needs to be treated.

12. MASKED HOMOSEXUALITY DREAM.

"We were in a house. Wife was lying on a bed. In another room there was an old man lying in bed. In the same room with my wife was another girl (friend) sitting on a hassock with just a kimona and her legs spread out. I could see everything—and reached over to tickle her sex parts. My wife saw me but there was no objection."

This is a wishfulfilling dream insofar as he wants his wife to approve of his scopophilia and extra-marital tendencies. The old man in the next room represents his super-ego, the father-analyst. Having another girl in the same room with his wife who was lying on the bed lends support to the theory that he most likely indulges in a fantasy of his wife having sex relations with another woman (masked homosexuality).

13. RELIGIOUS GUILT DREAM.

"I dreamed of standing or being called out onto the porch of a cottage, not my own home, to see the canopy of sky above literally filled with shooting stars. It was an awesome sight and I thought it was a sign of the Biblical prophecy of the nearing end of the world, but I was not unduly disturbed by the thought as I went back in the house to tell others to come and look.

"Some others were standing on the porch, but I cannot say who they were—relatives and friends. However, they were not strangers.

"The dream seems to fade away before anything more happened."

The Biblical prophecy of the nearing end of the world symbolizes anxiety and fear of God's punishment. The relatives and friends refer to his fear of their finding out about his exhibitionism (guilt).

14. PSYCHIC IMPOTENCE DREAM.

"I attempted to have intercourse with a friend or female relative but I did not achieve my goal."

This brief dream apparently suggests the element of psychic impotence associated with a repressed incestuous desire (coitus with a female

relative). The inhibition is due to some taboo.

In his associations to the dream he states: "I had an emission which awakened me just before having made an insertion."

15. NUDITY DREAM.

"I found myself in a public place partially dressed, minus my pants."

The above exhibition dream was accompanied by anxiety upon awakening for he stated: "I had the fear of having been watched by the police and got into the trouble."

DREAM 16.

"I was being hunted by the police for a murder that I was blamed for but of which I knew I was innocent; was shot at and hit, but don't recall any more details except that I seem to recall that I was exonerated before the end of this dream."

Patient evidently appeases his anxiety by ultimately being exonerated. On one occasion of exposing himself, his sentence was suspended. The word "murder" may signify a repression of his sadistic component.

DREAM 17.

"I was in back of a little country home where there was a female dog of the English bull type, with sex organs that seemed almost human and had a tremendous appeal to me as the dog seemed to be showing a passion for sex intercourse with me, which aroused my passion to the extent that I was at least thinking of attempting such intercourse."

This echo-dream is a carry-over into the unconscious, of actual experiences in childhood of sex play with animals.

DREAM 18.

"I was in front of a house. The street was deserted. It was dark. There was a couple making love on a porch. There were two women and a man. I wanted to get closer. I thought of getting in my car and driving on that side. The couple turned over so that the woman was getting on top of the man. I saw his penis slip out."

The two women and a man symbolize his triangular relationship to his wife and to his mother (Oedipus complex). It also signifies his identification in the dream with the man who has two women (extra marital fantasies approved by his wife—and a desire to have his wife homosexually involved with another woman (projection of his own homosexual component)).

The woman on top of the man denotes his masochistic role in sex relations. He has repeatedly said that he is more interested in pleasing a woman than in pleasing himself. Wanting the woman to take the active role on top also shows his unconscious homosexuality coming to the surface. This is further corroborated by the fantasy of seeing the man's penis slip out (a homosexual preoccupation—the desire to see his parents having intercourse once again and see his father's penis slip out).

In his dream-associations he tells us: "I've gone to roof-tops to watch couples in apartments. One time I even made a hole in somebody's ceiling so that I could observe them in bed. I have often had a feeling that I wanted to see two women gratify each other. I also would like to see a woman having sexual intercourse with a dog. Many times I would fantasy two women in the nude in the position of 69."

DREAM 19.

"I was on a golf course. It was rolling terrain. My friend cautioned me not to pick up the balls. They belonged to the players."

He is tempted to do that which is forbidden (pick up golf balls that did not belong to him). The other man in the dream represents his super-ego. The term "balls" may have a homosexual connotation.

DREAM 20.

"I went into a barber shop located in a tall building. I went there with the hope that I could look out of the window and see somebody undressing or engaging in sexual intercourse in the hotel across the way."

The dream is obviously voyeuristic in content. Mixoscopy constitutes one of his outstanding paraphilias.

DREAM 21.

"A rather young woman was completely undressed—nice figure. The window shade was up."

We find much evidence of his trend toward scopophilia in his dream life.

VIII. DISCUSSION

The patient, as we learned, is an educated man, 41 years of age, quite talented in music, who came from neurotic parentage and was brought up in a neurotic home environment.

There is considerable evidence of tainted heredity insofar as his mother is a highly neurotic woman, having engaged in voyeuristic activities in the presence of her son. The repressed incestuous relationship to his mother is quite evident, which indicates that a definite relationship exists between the Oedipus situation and his impulse to exhibitionism.

No doubt his religious background resulting in an accentuation of his super-ego has, paradoxically enough, enhanced his susceptibility to the gratification of his id-cravings. He had been conditioned to believe that sex, its expression or even discussion of it was bad and sinful. Hence the acute anxiety states which he experienced from time to time resulted from the guilt following his sexual transgressions.

Patient tends to rationalize his sexual aberration by blaming his wife, whom he describes as frigid. The desire to see couples engaging in sexual relations (mixoscopy) is a sequela, according to the anamnesis, of a psychic trauma which occurred in childhood. At the age of 10 he witnessed his parents having intercourse.

The inter-relationship between scoptophilia and exhibitionism is clearly demonstrated in this case. His libido became fixated at the erogenized eye-level, and regressed to the sexual immaturity of his childhood, evidenced by his desire to exhibit himself. This is in keeping with what we are told by Stekel that "during an attack the exhibitionist is a child again and judges the world according to infantile standards. In the attacks he usually resorts to children because then he too is a child." Patient has at various times exposed himself before children and adolescent girls. His paraphiliac requirements betray the extent of his psychosexual infantilism. As a child he was sexually precocious and developed symptoms of acute anxiety (castration-fears). The "stomach trouble" or duodenal ulcer was probably psychosomatic in origin. There is no evidence of epilepsy, alcoholism, disease of the brain or what may be referred to as constitutional pathology.

The onset of his exhibitionism can be traced to the age of 5 when he posed as a cow and exposed his sex parts waiting to be "milked." While he denied homosexual tendencies, his dreams tend to point toward a latent homosexual component. His dream-life also reveals anxiety (the fear of being caught by the police); there is one dream of psychic impotence and heterosexual inhibition (Dream No. 14) and several involving scoptophilia and exhibitionism (Dream Nos. 1, 2, 5, 12, 15, 18, 20, 21).

His narcissistic component, which is invariably found in every case of exhibitionism, is manifested by his desire to attract public attention via repeated exposures. He is usually in a dream-like state at the time. The impulse to display his genitals takes on a compulsive character despite the conscious censorship of his intellect.

The urge to show himself before women represents a substitute gratification or coital equivalent as overcompensation for the repression of his incestuous cravings. His childhood fear of a gorilla attacking him would be in keeping with this supposition, as it symbolizes his fear of the punishing father. In exposing himself he experiences the same erotic pleasures which he enjoyed in his childhood.

The psychic trauma of having seen his parents engaged in intercourse becomes the old experience which the patient is trying to live over again. This apparently constitutes the psychogenesis of his scoptophilia.

There is little actual masturbation for the purpose of physiologic relief. It is replaced instead by scoptophilia which gratifies him (psychic masturbation).

Patient stated that psychoanalysis enabled him to appreciate the psychologic roots of his sexual behavior, thus making the impulse to exhibitionism more amenable to control.

IX. SUMMARY AND CONCLUSIONS

1. The case concerns an individual, rather shy and sensitive to criticism, who indulged in pathologic scoptophilia and exhibitionism,

age 41, married, the father of 3 daughters, well educated, a church worker, talented in music, whose outstanding symptom is that of regression to psychosexual infantilism.

2. His cravings for sex gratification were intense, but along with it there were pronounced feelings of guilt resulting from conflicts between his id (antisocial behavior) and his super-ego (moral censorship) enhanced his anxiety to the extent of requiring psychiatric treatment.

3. The anamnesis reveals a highly neurotic mother (hysterical make-up) who is alleged to have shared with her son gratification from voyeuristic activities (mother and son would spy on couples to watch them indulge in physical intimacies). There apparently existed an unresolved Oedipus situation which consisted in a libidinous fixation on the mother. The compulsion to expose his penis before women (mother surrogates) represented in part a revolt against repressed incestuous desires. According to the patient's wife, the mother would insist that her son sit on her lap while she rocked him, referring to him as her "baby" despite the fact that he was 41 years of age, married, and the father of several children. This would indicate a neurotic mother-son attachment which can be regarded as an important etiologic factor in the development of the patient's sexual neurosis.

4. The choice of exhibitionism and scopophilia as outlets for his psychosexual infantilism is in keeping with a strong narcissistic component.

5. The patient's latent homosexuality was evidenced by a desire to prove his "masculinity" by showing his penis to women. It also represents the wish to have his mother expose herself in return. Exhibitionism of the genitals and the desire for exposure on the part of others, according to Stekel, go hand in hand.

6. Inviting the risk of being arrested for the second and third time can be construed as a masochistic need to be punished. It also gratifies an unconscious sadistic desire to humiliate his mother as well as his wife. To be arrested and regarded as a criminal means to be considered a man (overcompensation for sexual inferiority).

7. Patient collected obscene pictures and literature which he showed to his wife with the hope of enlisting her cooperation in the participation of paraphiliac activities. He derived much satisfaction from looking at pornographic illustrations and requested that he be allowed to feast his eyes on his wife in semi-nudity. Literally speaking, he enjoyed raping her with his eyes (scopophilia—a coital equivalent—a compromise for psychic impotence). He found in scopophilia and exhibitionism a mode of sex expression which he could not find in normal sex relations with his wife.

8. During the actual display of his genitals he enters into a dream-like, almost hallucinatory state. As is true of most exhibitionists,

he achieves his greatest satisfaction from the psychic reaction of the woman to whom he displays himself.

9. As a rationalization he attributes his weakness to temptation; to the fact that his wife is frigid and uncooperative.

10. There was no evidence of alcoholism, epilepsy or constitutional pathology.

11. Patient manifested a sincere desire to undergo treatment. Psychoanalysis gave the patient, for the first time, insight into the unconscious motivations behind his sexual aberration, making the impulse to exhibitionism more controllable.

12. Exhibitionism may be interpreted as the symptom-consequence of an underlying psychosexual neurosis and should not be regarded as a separate entity. Incarceration of the offender is a sterile method of handling the problem. It is wrong to think that the mere arrest of the individual will deter him from repeating his offense. The majority of exhibitionists are previous offenders. Psychiatric treatment, as Karpman has showed from his series of case studies, seems to be the only logical means of protecting society against the expression of this sex anomaly.

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PSYCHOSYNTHESIS

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INTRODUCTION

PSYCHOANALYSIS VS. AND/OR PSYCHOSYNTHESIS

After a period lasting from a few months to perhaps two years, more or less, depending on the case, the patient is discharged from the psychoanalytic treatment. In the course of this treatment he has been given insight into the workings of his emotional life, and the insight gained has enabled him to make a superior adjustment to life.

It is doubtful, however, whether on discharge from treatment the patient has suddenly emerged an entirely new personality, like the butterfly out of the chrysalis. More likely, the patient has been showing continuous improvement during his treatment, and this improvement continued with increased pace after the treatment so that it quite often happens it takes months, even years, before a final cure is effected and the patient gets the full benefits of the treatment.

It remains, none the less, a fact that however alert and well trained the analyst may be, it is not possible for him to perceive all the minute changes going on in the patient during the analysis; while, on the other hand, however intelligent and articulate the patient may be, it is not possible for him to express all that was going on in his mind. At best, we get only a fraction of the whole thing.

Analysis in its very nature implies synthesis as well. There would be no sense in breaking up a chemical compound into its various components unless we have in mind at the same time a recombination of these components into a new compound, which process is synthesis. Thus in the course of psychoanalytic treatment, as the patient's life patterns are being analyzed, synthesis is going on in the same time; and surely synthesis continuously takes place after the patient is discharged.

I am not unaware that Freud did not like the term "psychosynthesis," presumably including it in the concept "psychoanalysis," but in the present instance I am referring particularly to the re-integration of personality on the basis of insight gained after the patient is discharged. And with the analysis complete, there is full justification to speak of the process taking place in the former patient as psychosynthesis.

As the changes going on in the patient after discharge have never been adequately studied, it seemed desirable for our own benefit to evaluate more explicitly these changes. This I was enabled to do recently through the medium of a very intelligent patient of mine whom I asked, some months after treatment, to record for me these processes and changes both during and after the treatment. The material is given in his own words, the only corrections made being those required to

avoid repetition and irrelevant digressions. Considerations of prudence demand that the names, dates and locales be changed.

A. THE MEANING OF SYNTHESIS IN MY NEUROSIS

I understand that with the analysis completed, the problem from now on is largely one of utilizing the resulting insight into my own psychologic processes as a means of influencing my behavior. My task here now is not only to derive a notion of the general principles of my behavior from a review of the data revealed by the analysis (i.e., to synthesize) but to apply these notions to my daily life to the end that my behavior will be divorced from the neurotic conditioning factors which have so heavily and so unfortunately influenced it in the past. This latter objective is, of course, the ultimate one; and the primary objective—the synthesis—is nothing more than an approach to a realization of the ultimate problem.

The intermediate end product of analysis is the awareness on the part of the patient of the simple fact that his behavior is dominated by a mechanically complex but philosophically simple set of emotional relationships which traces back to his earliest emotional life. The keystone of this orderly tangle of relationships is a conviction of guilt, and the efforts of the patient to escape from the intolerable consequences of this conviction, or at least to mitigate its effort, creates a maze of contradictory, irrational and futile behavior which constitutes the neurotic personality.

Theoretically, once the patient is aware of this simple fact, he is free to readjust himself to the environment in which he lives and to re-create his personality according to a rational plan. Actually, this reconstruction, that is the synthesis, is extremely complicated and difficult. It probably can never be totally accomplished, and at least it takes time, patience and, depending upon the degree of complexity of one's individual environment, a greater or less degree of intelligence. Fortunately, however, it is entirely unnecessary to have one's personality under such rigid control as, say, a chemical compound. It is inconceivable that a life should be so ordered as to completely subvert emotional reactions to intellectual pre-determinations. An individual can be happy, normal and free and still be swayed by emotional forces. Indeed, it is of the essence of a happy life that within limits this should be so.

I now propose to examine the most important and most pressing problems of personality reconstruction with which I was faced during and especially after the analysis was over and set out what, in my opinion, is the progress I have made. In order to simplify the task, I have broken down the problem into the following categories.

- I. Conservation of Energy
- II. Productivity
- III. Sociability

These categories are set down in the order they occurred to me and with no notion of indicating their relative importance.

I. CONSERVATION OF ENERGY

The neurotic (if I am any indication) is the most profligate waster of psychic or emotional energy. This arises from the fact that energy is expended offensively (positively) and defensively (negatively) and from the further fact that the neurotic has so much to defend that his energy is largely expended in defense of his artificially vulnerable position. In this connection, a military analogy is very apt. It is axiomatic in military operations that the shorter the defense line the more sure the defense, and that defense should be limited to those points at which the line is really vulnerable. Any military commander who attempted to defend every possible point (irrespective of whether such points were valuable to or even desired by the enemy), and who actually invented imaginary vulnerable points so that defense must be spread still further, would find: (1) that he had no power left for offense and (2) that, by spreading his defense so thin, he weakened his whole line so that he had to have constant recourse to desperate and potentially disastrous expedients in order to keep his whole line from collapsing.

This is precisely what happens to a neurotic. He has to defend himself against his guilt. If such defense is inherently impossible (i.e., if the guilt springs from a continuing source which he is unwilling or unable to block) he defends by creating a diversion, that is, by setting up (inventing) an alternative position which is easier to defend. He must conceal his real purpose, however, and this leads him to constantly more complex inventions all of which require defense and leave him with no energy for positive action. This tendency after a while results in a definite pattern of behavior characterized by equivocation, misrepresentation and evasion. The process of analysis results, of course, in laying bare this behavior pattern. However, this is only half the story, since the neurotic in rebuilding his personality must rid himself of the pattern and in this task he must contend with a long established set of conditioned responses which lead him into paths of equivocation as naturally as a river bed leads water to the sea.

Consequently, the neurotic in rebuilding his personality must avoid equivocation and deceit as he would a plague. This is not a moral pronouncement but simply a practical necessity. Unless he makes substantial progress along this line, the individual can accomplish little, because otherwise he has no surplus of energy to apply to the positive task of reconstruction. In my own case (and I suppose in every case) there are several outstanding helps and hindrances to the development of strict candor and honesty. On the helpful side is first of all the awareness of the consequences of equivocation and deceit. Analysis has pointed up clearly the fallacy of expediency and, more important, has made clear the enormous and awful results of an accumulation of guilt. After analysis, there can be no question of the pointlessness and the insidious danger of deceit. Perhaps an even more important help in the elimination of deceit is the new formal ability to differentiate

between degrees of culpability. Prior to analysis, the feeling of guilt so hopelessly overlay every aspect of behavior that there was no separating it and measuring it in relation to specific acts. Thus, because of the tremendous reserve of guilt, and because of the interrelation of behavior, every culpable act, no matter how trivial, came to bear the same degree of guilt. Stated still differently, a minor omission such as the careless failure to meet an obligation in a timely manner could not be differentiated from a straightout act of physical dishonesty. After analysis, it becomes possible to attribute to every misdeed its due degree of culpability. Since such misdeeds are for the most part quite trivial, they carry stigma so insufficient that concealment is silly and certainly not worth the consequences of deceit.

On the hindrance side, it is my experience that deceit is likely to persist as a purely capricious habit of behavior. Say, for example, I have a letter to mail which I have forgotten to mail. Someone asks me whether I have mailed it. I know that if I admit my fault, I am subject to some degree of censure; I know that my omission can be remedied by dropping the letter in the box in the morning. Consequently, without any thought it is my tendency to answer falsely. This happened with alarming frequency for a short time even after my analysis was completed. It has a tendency to happen yet. However, I have schooled myself in the necessity of thinking before I reply to a question which if answered truthfully would subject me to blame. This device will always work because I have not yet encountered a situation in which the blame would even approximate that which would flow from a discovery of deceit.

It has been my experience that in developing a freedom from deceit and equivocation there are a number of dangerous possibilities. First, there is the possibility of building up the notion that candor and honesty are ends in themselves. I find myself at times taking independent comfort from the mere fact that I have failed to conceal a misdeed. This is, of course, quite wrong and potentially dangerous. Carried to the extreme, it would involve the setting up of standards of candor so pathologically extreme as to substitute such impossible (or at least impracticable) standards as a neurotic goal which would simply be a substitute for the original one.

Furthermore, I have found that in setting up too rigid standards of candor and honesty, there is a danger of subjecting myself to a series of crises any one of which might, if things went wrong, create such tension as to open up the possibility of a relapse into neurotic subterfuges. In other words, I have found it not dangerous to err occasionally, if I subsequently recognize my error and face its consequences squarely. I do not mean to suggest by this observation that a neurotic should taper off his bad habits but simply that good habits must grow (in the sense of natural growth of personality) rather than be forced by a rigid and mechanical intellectual discipline.

The neurotic (again simply using my experience as a guide) is

also a terrific waster of emotional energy in his sex experiences, attitudes and behavior. Having fixed the direction of his tender emotions towards an impossible and unattainable goal, he in effect spends all his time, energy and talent in rushing about furiously in all directions and to no purpose. In short, an impossible goal is no goal, and the neurotic, being driven by a bona-fide biologic urge, simply has no place to go. This induces panic, tension and frustration which operate in circular precision to make his life a horrible experience which only a neurotic can, I think, fully appreciate.

When it comes to a synthesis in this tremendously important field of emotional behavior, I can say that recovery (or perhaps better, the reshaping of personality) is more or less automatic. Habits in other fields of emotional behavior have a strong tendency to hold over capriciously from the heyday of my neurosis, and conscious activity is necessary to root them out. This seems not to be the case with deviations from the norm of sexual behavior. Perhaps I should elucidate this point.

During the height of my neurosis and, to a greater or lesser extent, during my whole life I was pathologically and preposterously pre-occupied with sex. That is my fantasies were predominately concerned with sexual experiences; every woman I passed on the street was appraised on the basis of possible sexual relationship; and every woman I met in ordinary social and business intercourse was considered not from the point of view of a friend, associate or acquaintance, but from the point of view of furthering my own sexual inclinations. Now this behavior did not tend to persist capriciously. On the contrary, about the time my analysis was completed there seemed to be a complete and radical change in my attitude which occurred without volition on my part.

The situation was something like this. In spite of the fact that I thought otherwise, I apparently (even during the most neurotic period) had a strongly developed intellectual philosophy of rebellion against established and conventional standards of moral behavior. In other words, I was basically a morally conventional person and my contrary behavior was compelled by the complex pattern growing out of the Oedipus situation. When the Oedipus situation was revealed (i.e., when I became completely aware of it), a great deal of capricious behavior persisted, but I seemed to be able (without trying) to make the main jump to normal sex behavior from neurotic behavior fairly quickly. I can illustrate with a few examples of recent as compared with prior experience.

For some six or eight months after the last date on which I had a drink, promiscuous sex activity continued to persist in fantasy. During this period, however, there intellectually began to intrude into these fantasies considerations contra to promiscuity. That is, a fantasy would be interrupted by matter of possible consequences tending to inhibit (or at least outweigh) the behavior indulged in, in the fantasy. These

interruptions became more frequent and more marked until finally they made promiscuous fantasy almost impossible. Now there are two points to make in connection with this observation. First, in the old neurotic days intellectual consideration of matter of fact consequences would not have been able to inhibit promiscuity in fact or fancy, because my behavior was dominated by neurotic emotional urges. Second, I do not attach any particular importance to the impingement of intellectual consideration into my neurotic shackles. On the other hand, it did not necessarily, I think, indicate any positive emotional re-orientation. Nor do I attach other than negative importance to several other developments which took place within the six or eight month period after the last drink.

For example, during this period I became aware that I was appraising women by an entirely different criterion than previously. My behavior in this respect for many years previously had been what I then thought natural and which now seems so utterly ridiculous that I sometimes find it hard to believe was true. It was literally true that I appraised every woman I came in contact with, whether as an acquaintance, in business, or simply to pass her on the street, in terms of her desirability or potentialities as a sexual partner. Naturally, this prevented all normal relationships and made it utterly impossible to evaluate any woman in any terms of the normal relationship between friends or acquaintances or business associates. When I found I was no longer doing this, I was pleased and encouraged. As time goes on, it becomes more definitive of a new orientation.

An important change did begin to take place, however, just after this six or eight month period. I began for the first time in my life to have a real feeling of tenderness toward Shirley. Shirley would not agree with this statement if I made it to her, because she is convinced that during the first years of our married life my tender emotions were centered on her. The real fact is, of course, that during this period I was mechanically attentive and devoted but my tender emotions were on a wild goose chase, and while they may have been centered on her, they were centered on her as a symbol. From her point of view this might have been just as good as the real thing but from my point of feeling for her, this is like nothing I ever felt before.

But in spite of the drastic change which has taken place in our relationship, I don't think I have quite yet made the grade with Shirley. This will take some little explaining. Shirley has met me at least half-way in every advance I have made toward her. This leaves me largely in control of the situation (which is perhaps as it should be), but I have a feeling that I have not gone as far as I should have. I don't know how much this is due to a holdover from the old neurotic situation and how much to a normal disinclination to surrender too completely to another person. Maybe I am making this appear more profound than it actually is. All I really mean is that I do not share with her as completely as I might all my feelings, hopes and ideas. There is

no logical reason for any reservations on my part and this would suggest that it might be a capricious carry-over from the old situation. However, I am convinced that the fullest married life requires a maximum of sharing one's most private thoughts and feelings and a minimum of reservation. So long as I am convinced of this as an emotional, as well as an intellectual, proposition I have no particular fear of any bad effects resulting from the present situation. So far as actual sexual relations between us are concerned, they flow naturally from the general emotional relationship, which is satisfactory and growing in intensity.

In the process of discussion, I seem to have gotten pretty far away from my original proposition of conservation of energy. However, I think this departure is more apparent than real. It is pretty obvious that a tremendous energy is generated by the sexual impulse or drive and that this energy may be dissipated by promiscuous and aimless expenditure. It is pretty obvious, also, that if such energy is concentrated at one point, it can and does accomplish wondrous work, just as does the water of a millrace when it is directed against the mill wheel.

A third device, the indulgence of which wastes the energy of a neurotic, is difficult for me to express in real or physical terms. But in the metaphysical sense at least, I think it can be said that a man has a limited store of emotional energy; he has a fixed capacity for producing energy. If this is true, then I think it can be said of the neurotic that he devotes a part (and often a major part) of his generating capacity to the production of energy which is discharged in lightning flashes of animosity and is, therefore, lost so far as producing any real work is concerned. Specifically, I think a part of what happened to me was something like this.

The Oedipus situation originally worked very simply. The feeling for my mother generated a great deal of potential emotional energy. It could not be discharged for obvious reasons in the manner which would naturally follow, that is, in demonstrations of love for my mother. This potential could not continue to be built up indefinitely, it must necessarily be discharged; and in the beginning it was discharged in a perfectly logical manner, that is, in the form of animosity toward my father who was the block against the hoped for (i.e., wished for) avenue of discharge. Now this is a waste formula par excellence. Love and hate in approximately equal proportions means the generation and discharge of energy with a net result of nothing accomplished. It is the exact equivalent, I think, of digging a hole in the ground and then filling it up.

In the more complicated system of rationalized behavior which ultimately developed out of this situation, the same result was reached, but in a somewhat more complicated and complex way. Emotional (sexual) energy was being generated and it was being dissipated in part in ways already described and in part by flashes of animosity not toward my father but toward symbols of him (i.e., in the form of

Oedipus created prejudices). There were other prejudices which were probably not Oedipus created but they were essentially the same in that they served principally as an outlet for a blocked potential energy.

Now in the process of my recovery, it seemed to me that my procedure was as follows with respect to my irrational prejudices. I thought that having had pointed out to me that certain of my prejudices were in fact irrational, I was able to apply my intellect to the resolution of all my prejudices. I am now convinced that I was wrong. It is indeed a fact that I have made tremendous progress in ridding myself of my prejudices but I now believe that I could never have made this progress by the exercise of intellectual processes. In other words, I believe that I never would have been able to have avoided some irrational outlet for my emotional potential so long as such potential continued to accumulate undischarged. Stated still differently, what I think happened was that the cure was made at the other end of the line. Although this is probably not good psychologic reasoning, it seems to me that with the exposure of the Oedipus situation, I ceased to convert my emotional energy into a straight sexual potential which was of a frequency, or tune if you please, such as to make it impossible to discharge normally. My conclusion is perfectly clear, and to me at least, it is convincing. It is simply that no longer needing an outlet in animosity for emotional potential, I was able to apply reasonable and intellectual processes to my prejudices and largely dissolve them.

The neurotic also wastes energy because of a false sense of values. The process is particularly clear in my case. It should suffice here to say that I had many such false goals, the main purpose of which was to pander my vanity and particularly to bolster my ego, which was carrying an intolerable burden of guilt. The false values have had marked tendency to persist, and I find it necessary constantly to be alert lest I do something solely looking to a goal which is no longer important to me. This is a matter in which reasoning processes are important, since the behavior to be modified is capricious and not compelled by some underlying emotional association.

II. PRODUCTIVITY

For purposes of discussion I have a rather narrow definition of productivity, that is, the doing of useful work. This has been (and still is) a sore subject between me and my conscience. During my entire adult life I have been keenly aware of the fact that my productivity has been unjustifiably low, and although I have tried (sometimes with success) to avoid such awareness, it has, nevertheless, always been more or less a thorn in my side. And although my productivity has vastly improved since my analysis was completed, I still have a long way to go. I think that my present productivity is inhibited (hindered) by at least the following: (1) A disinclination to proceed in a straight line toward a given objective. (2) A tendency to allow extraneous

and irrelevant considerations to influence my work. (3) A desire to be sure that I receive credit for what I do. (4) An inclination or tendency to sacrifice soundness to speed and dramatic value. The startling and somewhat alarming thing about weaknesses or deficiencies is that they are the precise factors which have always inhibited my work, although I must say that they are vastly reduced in importance. Perhaps I should take them up in order.

The disinclination to proceed in a straight line is probably a common human weakness amplified in my case by habits of behavior developed as an integral part of my neurosis. I take it that constructive thought is inherently a laborious process which is undertaken seriously and under the stimulus of self discipline. (Maybe that is putting the matter somewhat too strongly.) An analogy which occurs to me is the problem of a man faced with the task of plowing a field which differs markedly in difficulty from one end to the other. Now assuming that the farmer knows that, in all events, he must plow the entire field, he will, if he is a normal human being, have disciplined himself (or simply have learned) to plow the field in the most efficient way without regard to whether the difficult part of the job is done first, last or mixed in with the easy. So, I suppose, a well disciplined man doing intellectual labor would lay out a job and proceed with it in the most efficient way without regard to whether he did the difficult part first, last or in between. I find it very difficult to do a job in this way as a matter of course. My tendency is to proceed with a job until I hit a difficult spot, then to skip over to another easy part, leaving all the difficulties for the end, thus very often creating additional work because of having proceeded with the later part of it under false premises arising out of not having worked out my difficulties as I come to them. As I said, this is my tendency. I do not always work that way, but when I do work in a straightforward efficient way, I have to do it under the constant stimulus of conscious discipline.

I assume (and I certainly hope) that in time I may be able to dispense with this constant discipline and proceed in an efficient manner as a matter of habit. I assume, also, that my present bad habits were developed as a part of the whole neurotic rationale. Bad habits matured by my neurosis divide into two categories: those which seem to terminate almost automatically when the neurotic pattern is resolved (*viz.*, promiscuity) and those which have to be broken and reestablished by conscious effort. I expect the difference is in whether the habit is based on, or involved in, a basic emotion and is thus an integral part of the neurotic pattern itself or whether it is simply incidental to the neurosis. At any rate, I have accepted the proposition that in habits of work I must consciously attempt to readjust myself.

I find that in pursuing a given inquiry I am likely to be diverted from the main point in several ways. First, I may be diverted by a subinquiry which is relatively immaterial but which has greater dra-

matic value than the main line of thought. Second, I am prone to become infatuated with the sound of my own voice, so to speak, and to become more interested in what I say than in what it means. Third, if I am not careful, I find myself becoming more interested in speculating upon what someone else will think of what I think than in the validity of what I think. Now all of these things are common, I have no doubt. Nevertheless, they are faults which seriously interfere with important work and I would like to be rid of them. I expect no magic in this direction, and, furthermore, I see no way to eliminate them other than by conscious effort.

Coming to the third category which I set out at the beginning of this section, I suppose it is perfectly normal for people to desire that their accomplishments be recognized. However, as a general matter, these accomplishments are recognized in the long run, and there is no need to point them out no matter with what finesse or with what circumlocutory innuendo. This being true, it annoys me when I find myself making a remark which on analysis could have no other purpose than to draw attention to something which I have done and of which I am inordinately proud. Of course, there is no mystery about the origin of this habit. There is no doubt, either, that it is a bad work habit, since it sets an implied objective to every task that it be dramatic, positive and identified with me. Perhaps after repeated postmortem self kicks in the matter, I will overcome the habit.

The final work habit category which I set out above was a tendency to sacrifice soundness to speed and dramatic value. Once, many years ago, I ran across a simple personality classification, as follows:

Quick — Accurate
Quick — Inaccurate
Slow — Accurate
Slow — Inaccurate

If this classification has any validity, I am afraid that I would fall into the Quick — Inaccurate category, because I have the dangerous habit of jumping from one tentative conclusion to another in an impatient attempt to get to the final answer quickly. More specifically, when a final answer begins to suggest itself, I am fired with a desire to capture it quickly and I am inclined to race through the intervening steps lest the answer elude me. Now, this habit is potentially very dangerous. I have been very lucky with it, because I have had so much experience in the matters with which I am working that quick and untested judgment very often prove to be so nearly right as to create no great danger of a bad mistake. But it is a very bad habit, none the less, and one concerning which I have been most apprehensive. It can be avoided and I have avoided it but a lifelong practice is very hard to revamp. But here, again, I don't think there is any magic rule. I know what the problem is, and I think it can only be solved by conscious effort.

III. SOCIABILITY

There were a number of factors which made normal social intercourse difficult for me almost to the point of impossibility. Probably the most important of these were: (1) A tendency to consider every female acquaintance as a potential sex objective. (2) A notion of superiority with respect to most male acquaintances. (3) A notion of inadequacy to deal with anything even as unimportant as routine social obligations. These tendencies were all an integral part of the neurotic pattern of behavior, so that, contrary to work habits previously discussed, they had a tendency to disappear almost of their own accord when the neurosis was resolved.

It is in this relatively unimportant field that I have perhaps made the most spectacular progress which has manifested itself in a number of ways. In the first place, I find myself seeking and enjoying masculine companionship to the extent that makes my previous avoidance of it almost unbelievable. During the past year I have developed a deep and lasting affection for two or three of my associates, a thing which never could have happened previously. I have come, as a general proposition, to prefer masculine companionship to feminine, which is again a drastic switch. This has brought about a new understanding of men, the importance of which is difficult to put into words. There are, of course, certain obvious things which are clear. For example, all sorts of ridiculous misconceptions, which now seem almost too silly to mention, have disappeared into thin air. I no longer assume that all men are promiscuous, that most men are callous and insensitive, that masculinity means *gaucherie*, crudity and cruelty, or that most men are simply tolerated by and are not attractive to women.

But far more important than this is that the new understanding of masculinity gives me a new sense of personal dignity. I am actually proud to be a man and perhaps just a little bit intolerant of feminine frailty. This is the very opposite of what I previously thought. I don't know that carried to an extreme this is a particularly admirable trait, but I am convinced that it is normal and healthy. Furthermore, in understanding men I am no longer afraid of them. Nor am I afraid to compete with them. I know there are men who are stronger and weaker than I in various ways. I think I am no longer in awe of the one or contemptuous of the other. I think I can also truthfully say that when in competition I am beaten or I win, I am neither depressed nor smug as a result.

Perhaps the most important thing of all, so far as my working relations with men are concerned, is that my judgments and tactics are no longer dictated by prejudice and fear, but by what I like to think is true (although not complete) insight into their motives and varying personalities.

I do not think that my improved relations with men have damaged my social relations with women although it has obviously changed

them. When I meet or talk with a woman now, there is no undercurrent of equivocal motive to put our relationship on a false basis. For the first time in my life, I am successfully able to indulge in small talk with a woman for the reason that I am in no fear of repulse, since there are no concealed advances or proposals in my small talk. Small talk has come to mean exactly what it is, that is, inconsequential conversation with no meaning, and meant to be forgotten at the next moment. I think that I should add that my new awareness of human motives and personalities has made it possible, on the one hand, to avoid unnecessary hurt to other people and, on the other hand, to proceed directly and expeditiously with the immediate business without undue fear of how other people are going to react.

(To be continued)

A REPORT ON THE INTERNATIONAL MENTAL HEALTH CONGRESS*

The International Mental Health Congress was held in London from Aug. 11 to 21, 1948, and sponsored by the International Committee of Mental Hygiene.

The reason or need for the Congress arose out of the belief that there are millions of people in the world who constitute a serious threat to world security because of being emotionally "out of step" as it were. As a result we are finding ourselves living in a world of stress, tension and anxiety. Since Mental Hygiene teaches men to live harmoniously with one another, it is the duty and obligation of not only psychiatrists but members of allied professions to accept the challenge of recommending measures toward improving the present world situation. It was the consensus of opinion that a system of world mental health planning would be a step in the right direction. Such a system would naturally require team work from mental experts representing countries who wish to participate in efforts directed toward the achievement of a common goal—world survival and world progress.

The last International Congress for Mental Hygiene took place in 1930. Since then Mental Hygiene has spread widely while psychiatry has acquired greater insight into the unconscious motivations of human behavior, particularly as a result of our experience in the past war. The new Congress, thus, represented a world wide mobilization or pooling of professional knowledge. The inspiration for its organization arose out of the premise incorporated in the Constitution of the UNESCO namely: "since wars begin in the minds of men, it is in the minds of men that the defences of peace must be constructed", or as some one has differently stated "more than a fair share of the ills of the world arise from circumstances which might be avoided through the fuller understanding by man of his own psychology and mental outlook". Toward the achievement of this goal the Congress enlisted the cooperation of physicians, psychiatrists, psychologists, social workers, nurses, clergymen and many others.

According to the literature made available to the delegates, the Congress had three important objectives:—

- (1) "—to effect the most complete exchange of knowledge, experience and techniques in the field of mental health possible, and to effect this exchange as quickly as possible.
- (2) "—to disseminate information regarding the Congress findings as broadly as possible to all those concerned with mental health.

*Read before the Washington Society for the Advancement of Psychotherapy, Dec. 10, 1948.

- (3) "—to bring into being the nucleus of a permanent world-wide voluntary mental health organization to carry out an active program for the promotion of mental health."

A specific accomplishment of this London conference has been the formation of a World Federation for Mental Health, whose purpose is to formulate recommendations for a universal mental health program to the United Nations Educational, Scientific and Cultural Organization (UNESCO) of which Dr. Julian Huxley is Director General. Dr. Brock Chisholm, Executive Secretary of The World Health Organization, has also lent his cooperation toward making the Congress a success. The Chairman of the conference was Dr. J. R. Rees, Psychiatric Consultant of the British Army.

There were approximately 2,000 delegates who attended, representing fifty-four different nations. Dr. Rees found occasion to announce that he was unable to explain the conspicuous absence of Russian delegates. There were close to 400 from the United States who attended the Congress. Among them were Drs. W. Overholser, Fremont-Smith, Carl Binger, Fred Allen, George Stevenson, Lauretta Bender, Daniel Blain, Karl Bowman, John Whitehorn, C. C. Burlingame, J. M. Caldwell, Felix Deutsch, Flanders Dunbar, David Levy, Sandor Lorand, S. B. Wortis, H. Stack Sullivan, R. Felix, Lawrence Frank and many others.

A RÉSUMÉ OF SOME OF THE PAPERS PRESENTED

All speakers were required to read their papers in one of two languages, English or French.

The Congress consisted of three sets of conferences: (1) The International Conference on Child Psychiatry. The discussion dealt with the theme of personality development in its individual and social aspects with special reference to aggression. (2) The International Conference on Medical Psychotherapy. The theme selected for this conference was "Guilt". (3) The International Conference on Mental Hygiene, which concerned itself with the theme of Mental Health and World Citizenship.

The main speakers of the first conference were Anna Freud and Frederick Allen, Director of the Philadelphia Child Guidance Clinic. The topic Aggression was selected because it was believed that we cannot adequately understand the dynamics of abnormal emotional development until we thoroughly understand the problem of aggression in children; that social disharmony is brought about by the pathology involved in aggression. Anna Freud's paper dealt mainly with the Freudian Theory of Aggression, namely, that aggressive urges arise out of the destructive or death instincts and their counterparts, the sex urges, representing the life instinct. The so-called phenomena of life consist of the combination of these two basic instincts, the death instinct and the life or sex instinct. Aggression becomes intimately associated

with developmental phases of infantile sexuality at various levels (oral, anal and phallic). It is through aggression that the libido impulses achieve their aim. Both destructive and sex urges, according to Anna Freud, satisfy themselves in the individual's own body before they become directed toward objects in the external world. Modified forms of these urges consist of reaction—formations and sublimations. Where emotional starvation occurs, a normal fusion of these two instincts fails to take place. Psychotherapy, therefore, should aim at restoring the child's love and sex life in order to neutralize the destructive forces which are apt to lead to destructive aggression in adult life.

Dr. Frederick Allen attempted to show, in direct opposition to the freudian viewpoint, that aggression is not the basis of the death instinct but is linked with the life instinct. He points out for instance that the infant's first aggressive act—the reaching out for food—is in response to a disturbance of his own internal equilibrium. In other words, the infant is aroused to action by his physiologic needs. Aggression is further interpreted by Allen as an attempt to recapture the sense of oneness with the mother which had been broken by birth. It is this separation from the mother which tends to produce in the child a state of anxiety (Rank's view). Aggression is also manifested when the child's need to satisfy a drive is blocked. When the parents fail to handle these frustrations properly, the aggression of the child becomes destructive or pathologic. Neurotic parents are unable to appreciate the fact that every child wants to grow up to become an individual in his own right. Dr. Allen does, however, subscribe to the freudian association of frustration with various anatomic areas of the child's body. In describing the oral role in the emotional development of the child, for instance, he states that "the mouth becomes the first medium for expressing feeling either to indicate through crying, a need for food, or to express anger when sensing frustration." The inability on the part of the parents to regulate the feeding requirements of the child emphasizes the negative component of aggression which, Allen claims, constitutes the basis of major conflicts between child and parent, and later between the child and society. He goes on to say that training in habits of cleanliness, involving urethral and anal control by the child, also creates additional conflicts—resulting in negative aggression. The child finds outlets for negative aggressiveness through fantasies. He builds up defences against parental frustrations which lead to abnormal expressions of aggression. Allen concludes his paper by stating that children must be allowed to "aggress and find their place not just as individuals but as creators of the ever new, needed to sustain the virility of the human race."

There were several other contributions, one entitled "Aggression in Relation to Family Life" by Dr. R. MacCalman, Professor of Mental Health, University of Aberdeen; another on the same topic by Dr. Torsten Ramer, Chief Psychiatrist of the Child Guidance Clinic, Stock-

holm, Sweden. Dr. Carlo De Sanctis, Assistant Director of the Psychiatric Hospital in Rome, read a paper under the title of "The Community and the Aggressive Child". A paper by the same title was also presented by Dr. George Gardner, Co-Director of the Judge Baker Guidance Center in Boston, Mass.

It would be too great a task to make an abstract of each paper presented. For the sake of saving time and space, this report has to be limited to a brief description of some of the more salient ideas and suggestions offered by those participating in the discussions.

As was previously mentioned, the theme of the second conference—The Medical Psychotherapy meeting—was "Guilt." Dr. Winfred Overholser presided. This turned out to be a stimulating symposium, as the speakers represented different schools of thought. Guilt was discussed from the medical, legal, ecclesiastic and philosophic points of view. Dr. John Rickman, from the London Clinic of Psychoanalysis, presented a paper entitled, "Guilt and the Dynamics of Psychological Disorder in the Individual." He attempted to explain the reason for the diversity of opinions regarding the understanding of guilt. For example, the psychoanalyst studies guilt from the standpoint of the individual patient's reaction to personal experiences. To use his own words, he interprets guilt "as a manifestation of tension existing within the individual and arising from the interplay of the person with the environment: from an absorption of a part of the environment into the self." According to many psychoanalysts, guilt results from tension between the individual and the social code which, in turn, is derived from the child's relation to his parents, a resistance to parental discipline. Dr. Rickman feels, however, that guilt cannot be isolated; it is too intimately connected with other psychic actions. He cites, for example, the depressive or persecutory sort of deep-rooted mental pain arising when "a person projects on to the outer world feelings of hostility which he cannot tolerate within himself; the person then feels the outer world to be bad and aggressive, and he himself, by contrast, to be innocent."

He claims we feel guilt when we behave in a way to invite parental disapproval—when we injure a loved person. The neurotic never forgets the past. The repression of guilt-producing experiences causes him anxiety and mental pain. Rickman further holds to the Freudian doctrine of guilt in relation to the Oedipus situation—the early love-and-hate relationship of the child to both parents. He makes the following interpretative and significant statement: "It is the reaction to the guilt of the early period of life which gives us our proneness to mental illness and instability, to crime and also to our loftiest aspirations and achievements—in a word, which makes us human." Our super-ego or conscience is derived from energy resulting from aggression turned against the self. He describes two kinds of guilt—depressive and persecutory; the former due to injury done to a loved object

and the resulting pain of isolation, and the latter due to projected hostility returning upon the self as dread of punishment.

He summarized his paper by describing various individual reactions to guilt. He courageously states that religion fails to take into consideration the phenomenon of ambivalence for the same person, and has never recovered from the mistake of dividing God and Devil. Psychotherapy to be effective must enable the individual to abreact his early emotional situation of ambivalence, so that he can readjust himself to a better appreciation of himself and to his surrounding world. The problem of guilt unfortunately influences the international status of mankind.

Margaret Mead's paper entitled "Collective Guilt" was received with much interest and commendation. She approached the subject from the standpoint of a comparative study of cultures. She defined guilt as an "internalisation and expectation of sanction under which the individual feels either anticipatorily or retrospectively the type of punishment which he once experienced, in which, in fact, the individual is able to inflict upon himself the suffering once inflicted by parent or parent surrogates." She showed, for instance, how many soldiers suffered neurotic difficulties associated with guilt reactions following the act of killing in obedience to an order. Among North American Indians guilt became associated more with the disapproval of the whole group than with the fear of punishment by the parents. For instance, an Indian could be so shamed by his paddle breaking that he would commit suicide. Speaking of collective guilt, she mentioned that in Japan the child is taught that its entire family can be disgraced by a single act on its part and was sometimes punished by kindling a fire on its navel. Guilt was experienced when the reputation of the family was jeopardized. There developed a group responsibility for the misdeed of the individual. The Japanese believe in an absolute loyalty and responsibility to the group to which you belong. Suicide often resulted because of guilt feelings associated with disloyalty to the group. She referred to the school masters who committed suicide when their school house containing pictures of the emperor burned down. In elaborating on other varieties of collective guilt, she finally concluded that medical psychotherapy applied to the improvement of world organization, must not overlook anthropologic considerations such as a recognition of the differences in character, social, family and political structures.

Dr. Krijers-Jansen, Psychiatrist from Hilversum, Sweden, pointed out that some psychoanalysts believe that collective guilt caused by moral restraint was responsible for the aggressive trends seen in war and in the struggle of the classes and races, suggesting that greater sexual freedom would solve the problem. Others find in the relations between nations shame and blame, narcissism, race-hatred, the struggle for prestige, aggression and counter-aggression. He described collective guilt in terms of the biologic, social and spiritual spheres.

Rev. Thomas Gilby, from Emmanuel College, Cambridge, read a paper entitled "The Genesis of Guilt," which in substance incorporated the idea that any discussion of guilt without religion would be equivalent to a Hamlet without the ghost or, vice-versa, the ghost without Hamlet. In expounding the religious theory, he made the remark, "It is probable that the maddest people are not seen by the medical psychologist just as the most vicious people are not seen by the priest."

Dr. Ernest Jones, President of the International Psychoanalytic Association, referred to the sense of guilt as highly complicated, the product of vicious circles, requiring much more investigation that it had hitherto received.

The last conference was limited to a discussion of Mental Health and World Citizenship. Dr. Carl Binger, Associate Professor of Clinical Psychiatry, Cornell University, read a paper entitled "World Citizenship and Good Group Relations." In substance he emphasized that the prevention of war should be a first and chief concern; the need for a world government, he claimed, is already here. He went on to say that in so far as we recognize this need and feel its imperative urgency we have taken the first step towards being citizens of the world. He adds a serious note by reminding us of Toynbee's warning that nineteen of twenty civilizations have gone to their death through war or internal conflicts, or some combination of the two; and that if we do not learn to prevent war, not only is civilization fated to annihilation but the human species as well. This Binger regards as the challenge of the Congress. He feels optimistic nevertheless as evidenced by the implication that the constructive forces both in the individual and in society will spontaneously find their way when the forces of fear and anxiety are removed. He, too, questions the assumption that man is possessed with a destructive or death instinct. In fact, he asserts that war cannot be attributed to a single cause. To attribute war to a vicious capitalist system, he claims, would be an oversimplification. There are a multiplicity of causes, economic, racial, religious, hurt pride, ancient traditional hatreds, etc., and he points to the fact that a decision to make war in many instances appears from one to five years before the actual outbreak of hostilities. He concludes by saying that the world cannot be saved by scientific conferences; that psychologic insight must be passed on to those statesmen and politicians responsible for the action of their respective countries.

Professor J. C. Flugel summarized the contributions of the various participants and submitted the following four main conclusions which were drawn from the work of the Congress:

- (1) "The rich possibilities of improving the mental well-being of man depend upon his modifiability, both as an individual and as regards the societies in which he lives. Individual and social health are, moreover, interdependent, so that the problems of mental health must be attacked from both ends.

(2) "A rapid improvement in mental health can only be obtained if many different professions co-operate; hence the need for the multi-disciplined approach.

(3) "Under present-day conditions, full mental health is only possible with reference to 'one world'. Hence the emphasis on World Citizenship, which has been interpreted however not so much politically but rather as a spiritual acceptance of world community, which implies that one society cannot permanently prosper at the expense of another.

(4) "Nevertheless mental health principles are applicable within the general framework of different culture patterns, ideologies or religious systems."

The response to the call for the organization of an International Mental Health Congress has been gratifying to say the least. The need for some planned action whereby people can be taught to live harmoniously together is obvious judging from the present international situation. The attendance of enthusiastic delegates representing divergent schools of thought from fifty-two nations is in itself proof that psychiatrists have advanced to the stage of "doing" something instead of merely "thinking" about it. They now agree that scientific knowledge is sterile without its useful application.

It was encouraging too to learn that Julian Huxley favored putting on the program of UNESCO the study of the application of psychoanalysis to education for the purpose of regulating repression which many believe to be responsible for neurotic disorders.

There is little doubt that this international meeting of Mental Hygienists will help further the development of psychiatric research. It will go down in history as a most important step taken toward finding the solution to world disharmony and promoting better world citizenship.

Delegates who came to London from the far corners of the earth, returned home stimulated by the spirit of teamwork manifested at the Congress and satisfied that a united effort was at last in progress toward the possible prevention of future wars and the safeguarding of peace. One left with a feeling of satisfaction that something had actually been accomplished and a responsibility that more needs to be done in the way of re educating the masses to a healthier way of living.

At the same time, while there is undoubtedly much to be said on the positive side in behalf of these who worked hard to make the Congress a success, there are a few criticisms which deserve mention. From people who attempt to teach others the principles of tolerance, one has the moral right to expect that they will practice it among themselves. In the opinion of many who attended the Congress, someone should have taken the time to address those who need to take an inventory of their own intolerances before they can teach others a way of living harmoniously with one another. Any group of psychoanalysts who show evidence of rigidity, and are intolerant of their psychoanalytic

colleagues (Stekelians, Adlerians, Rankians, Jungians) who have departed from some of the original orthodox technics of Freud, represents a contradiction of what the Congress stands for. It was expressed that some of the participating delegates, because of their overt display of professional prejudice, could stand a little psychotherapy themselves. When any system of thought practically turns into a cult, as evidenced by the very rigid requirements for membership, those responsible are not advancing thereby the cause of science. It is only by setting a good example ourselves through personality integration that we can qualify not only as psychiatrists, psychologists, social workers or psychoanalysts but as mental hygienists. Many toes had to be stepped on because of the controversial nature of the subjects discussed. Despite the disappointment expressed by many of the delegates, it is probably better to challenge concentrating our efforts in the direction of a better and healthier world, no matter how slow the progress than to yield to our deficiencies, stalemating ourselves by an exchange of criticisms in the absence of constructive action.

It is hoped that at the next International Congress the subject of Insecurity and its many aspects will be discussed as an entity. Fear, which, of course, is intimately associated with the problem of insecurity, can well be the common denominator of civilization's ills. The adoption of a universal way of life based on principles of Mental Hygiene seems to be at least one effective method of social discipline that may bring us closer to our utopian goal. Our first duty is to expand our knowledge of the causative factors responsible for a civilization in which a mentally sick individual lives in a mentally sick society. Psychoanalysis already has given us the key that has opened the door to a better understanding of the unconscious motivations of human behavior. Regarding the prognosis of man's efforts to achieve world peace, it is gratifying to observe that Freud was optimistic and encouraging, as evidenced by the following statement:

"I would not say that such an attempt to apply psychoanalysis to civilized society would be fanciful or doomed to fruitlessness. With regard to any therapeutic application of knowledge what would be the use of the most acute analysis of social neuroses since no one possesses power to compel the community to adopt the therapy? In spite of all these difficulties, we may expect that one day someone will venture upon his research into the pathology of civilized communities."

As a closing thought, I believe that man is basically possessed with a will to survive—a will to love; that hate is a reaction to our fear of insecurity. There are many besides myself who do not subscribe to the theory that man is possessed with a destructive or death instinct. On the contrary, with many others I believe that man's irrational behavior may be interpreted as a defence against a feeling of insecurity,

which can be traced to a latent frustration of having been "born to die".

Can human behavior be explained on the basis of our ambivalence toward an environment that threatens us with a premature physical or psychologic death? Are all anxiety states according to Stekel, the result of man's fear of death? Karpman advances the theory of man's struggle for power as growing out of a deep-rooted sense of insecurity, that insecurity is the basic influence of all our actions. At any rate, these are a few of the problems that should be a challenge to future investigators who wish to search for the underlying cause of our present world-sickness. Their findings should be made known to the delegates of the next Congress and to the world at large.

Frank S. Caprio, M.D.

STANZAS ON PSYCHOANALYSIS

EDNA FLORANCE

I used to think that pains and ills might all be cured by liver pills,
Pink medicines, or lozenges, or potions.
At the least indisposition, I would phone for a physician;
I never thought of blaming my emotions.

As for the lowliest M.D., his art seemed more like wizardry;
He could, I thought, cure anything, from pimples to paralysis.
Ah, never more will I betray such innocence, such naivete,
For that belongs to years B.P. — Before Psychoanalysis.

How fortunate it was for me that here in Washington, D. C.
Psychoanalysts abound: do these chaotic
Days, with the Atom Age at hand, create unusual demand?
Or are congressmen inclined to be neurotic?

Now I need no diagnosis, for I know that my neurosis
Is the cause of all the ailments I deplore.
Dr. X seems quite assured that when—and if—I shall be cured
All my symptoms will be gone forevermore.

So now, throughout our daily tryst, this kindly psychoanalyst
Must hear me tell my troubles, doubts, and fears.
Sometimes I think he may be bored, but though he yawns, he's never
snored;
He lurks behind me, making notes on what he hears.

It's a curious situation, for in free association
I must tell him just what comes into my head.
And spontaneous confessions sometimes deal with indiscretions,
So I often blush to think of what I've said.

Emotions bottled up in me like poisons, cause me misery,
Cause headaches, indigestion, and no doubt
Make me cross and make me snappy; I can't be serene and happy
Until I cast these bad emotions out.

So, while upon the couch I lie, I let my pent-up feelings fly—
Resentment, jealousy, vexation, rage and gloom,
Indignation and suspicion, guilt, revengefulness, contrition—
Such a force could blow the roof right off the room.

But, out of reach of threatening fist, there sits the psychoanalyst,
Calm, sphinx-like, in the shadows just behind me.
He finds nothing dull or shocking, just wants me to keep on talking.
If I hesitate—"I'm listening," he'll remind me.

All my dreams, bad, sad or sweet, I must cast them at his feet,
And he grasps at them with eager, greedy eyes.
And what seems a trifle grim; if I chance to dream of him
I must tell him what I dreamed—and tell no lies.

It has at least done this for me; there is no more of mystery
Concerning my emotions, good or bad.
I still hope that psychiatry may cure all my anxiety,
If not—what an experience I've had!

Critical Reviews

The Creative Unconscious. Studies in the Psychoanalysis of Art. Dr. Hanns Sachs, Cambridge, Mass. 1942.

These studies are the by-products of a practicing psychoanalyst, collected in the course of a quarter century. Certain clues in the case histories of mental patients encouraged the author to formulate tentative theories of what is back of literature, history and art.

The discussion in the *Community of Day Dreams* starts out with a case for psychoanalytic theory based on the relationships that exist between dream, day dream, poetry and literature. A recital from psychoanalytic practice of a mutual day dream involving punishment to a third person is interpreted as a protective device against anxiety. Two people take pleasure in another's misfortune because this misfortune is an appeasement of an unconscious wish on the part of each participant that demands punishment.

Heightened tensions, restlessness, absentmindedness, depression and the like are said to be present in the creative act, indirect signals of unconscious contents disguised as a facade which is beauty. The painful content, we are told, is but a screen for real but unconscious pleasure. Where the unconscious participates, impressions are lasting, hence great art fulfills a social function. By contrast, the happy ending story, being merely entertainment, is short-lived and demands constant replenishing. Where content and form are badly joined with the unconscious, where in literature imitation, fashion and tradition are unduly apparent, the effect is superficial, and real artistry is not achieved. Those writers who merely externalize their day dreams for the pulps or comics, according to the author, reveal narcissism at the sacrifice of art.

It is easy to understand day dreaming where pleasure is the goal but why should we take satisfaction in pain? Insight gained from the study of neurotic patients, as in the above case, is said to clear up this point. It is true the neurotic situation is clear but nothing comparable is offered from the field of literature. But we would like to know more of the unconscious drives in literary-artistic creation that we are told are more active as in "guilt-feeling" romanticism and less active as in "narcissistic" classicism. Substantiating evidence is not easily obtainable and progress is necessarily slow. Apparently the author had no opportunity to analyze a great writer and thereby come to grips with literature in the concrete. That lack may explain the fragmentary character, which of course could not be helped.

In all this, beauty is not defined; it is "a facade, a set of devices" the writer uses to make acceptable his unconscious urges, whatever they may be. To the author beauty is many sided and exists in many places. It is taken for granted or it is a feeling that cannot be explained.

The brief chapter *Personal and Impersonal Art* is condensed from

a more lengthy contribution to *Imago* (Kunst und Persönlichkeit, V. XV, 1929, p. 1ff). Here the author deals in terms of psychology with Byzantine mosaics, a style of early medieval wall decoration in which small cubes of marble and colored glass are used. Because of regression and a weak and infantile ego, mosaics were developed. There were of course other reasons too, but we are here interested in the psychologic factors. The impersonal technic of mosaics, so childlike in its simplicity, was eminently suitable to the transcendental character of the Christian religion. Because there were no conflicts between repression and the unconscious, there was no occasion for the creative process to come into being. The psychologist here supplements the art historians.

In a discussion of Shakespeare's *Measure for Measure* the author brings his psychologic insight to bear on the chief character, a judge, who is an obsessional neurotic in whom cruelty and sexuality merge. Aroused he aims to satisfy both urges and the plot develops out of the way he is frustrated in achieving his ends.

The judge as criminal is the problem of Oedipus, King of Thebes, who unaware of his guilt must judge himself. The author calls attention to this universal theme, suggested by the biblical "Judge not . . ." by relating it to Hamlet and Dostoyevski's *Brothers Karamasov*, all dealing with the same theme, the identity of judge and transgressor. In Christian ethics it is called original sin; in psychoanalytic terms, it is the Oedipus complex. The threads of the play are gathered and held up to the light of analysis, virtually saying the great poets understood well what in more laborious piecemeal fashion comes to light in psychoanalysis. Thus ancient wisdom here receives the sanction of modern psychology.

The *Delay of the Machine Age* is a fascinating study, perhaps the most illuminating of the series. In other fields than technology the Roman Empire represented a high level of intellectual activity. Literature, history, mathematics, natural sciences and astronomy flourished but there were no machines. In that respect mankind, in the days of the Caesars, was no further advanced than the Egyptians had been a millennium and a half before their time. Our author suggests the answer: Man's repugnance toward mechanical inventions turned them into playthings, because his self love would tolerate no devices that seemed to rival human performances. Such an explanation, pointing to a flaw in man's emotional make-up, should not surprise us today when we are so conscious of man's struggle to control himself. But our author does not use this argument, instead he points out that the historical explanation, the existence of slave labor is inadequate. Actually during the centuries of the *pax romana*, the supply of slaves was running down, and humane sentiments against slavery were gaining ground. There really was a need for machines and the technical knowledge to make them was available. Moreover, what few machines had been developed were the result of discoveries based on scientific data, not mere chance findings. And yet hydraulic pressure was used only for shifting scenes

in the circus and an automatically driven marionette theater was invented for amusement. Thus removed from practical affairs, machines did not have to be taken seriously. The nearest approach to a practical application was in religion, in the holy water slot machines of Egyptian temples which operated on the insertion of a coin.

Man of antiquity possessed an abundance of self love which he projected in art, as in sculpture, with its emphasis on the perfect human body. A comparable example of self love is quoted from psychopathology, where the schizophrenic projects his body out by way of an allusion of an influencing machine. In 1 case man tolerates no machines to rival human performances but creates his own images in the form of sculpture. Narcissism is controlled, statues glorify man but they keep their place, they do not embarrass him the way machines do.

In the other case, narcissism is uncontrolled, it is also cast out, not in the form of lifeless but flattering sculpture but as a mechanical contraption that is like man and capable of influencing him. The author's thought is revealing, it could be made to illuminate the whole development of western sculpture.

Thus a machine can become a symbol of man, perhaps even robbing him of his soul. Hints from literature are brought in to support his thesis. The German poet Heine had a sense of the uncanny; he is even filled with horror, when observing machinery that seems to have the perfection of man, making man "mindless, machinelike and hollow."

These examples tend to explain why the machine was so long in coming. The inhibition that prevented man from allowing his imagination free scope in the technologic field involved horror as well as narcissism. The author says no more about horror, except for his quotation from Heine. To our mind it is important. Imagine how horrible one would feel if suddenly inanimate objects would start to move. We can still recall childhood experiences that caused us alarm if we thought something moved that was not supposed to move.

In the *Introduction to Beauty, Life and Death* the author takes up subjective and objective aspects of beauty, finding truth in both. He concludes his thesis by pointing out that new beauty in nature is discovered by a gradual reduction of anxiety. In itself this is no new discovery but linking beauty to anxiety and pointing out that the two cannot exist side by side, is a novel extension of an old thought.

Beauty like pleasure, according to the author, is one of those phenomena that enters into "strange mixtures and intricate compositions." Beauty contains pleasure and other constituents but what they are is a problem.

Beauty in art we are told makes for bonds of sympathy between people. Pure beauty in its highest manifestation means expansion toward a miraculous isolation; "It is intra-psyche and occurs in a state of exaltation in poets and artists at the time of inspiration." Such expressions too could be developed into separate investigations. The

many approaches to the problem of beauty are referred to, and attention is called to the limited application of existing theories. Psychology in its quest for beauty confuses beauty with pleasure, but esthetics, as a branch of philosophy, at least worked out the idea of beauty as something universal to mankind. It is this seeking for universal validity that the psychoanalytic approach is aiming for.

The freudian explanation of beauty as sublimated object-libido comes in for criticism in its lack of a solid foundation, and in the fact that it leaves too much unexplained. As for the author's explanation of libido and beauty, he believes we can utilize beauty only in small quantities, for to experience great beauty brings on isolation and sadness. It is not sought but avoided; most of us take beauty in small quantities, well mixed with interest and action. The author makes some good observations on human behavior in art galleries but it is not quite clear what he means by "utilization of beauty in small quantities." This part of his argument needs to be clarified. On the other hand, we believe he is right in his statement that everyone potentially is able to discern beauty, not just a few rare spirits. This is followed by another perplexing statement, his belief that one must have certain qualities, as yet unknown, that "make the mind unafraid of its (beauty's) impact, so that it does not shut itself in or run away from beauty, as a form of danger to its well being." This aspect of the author's theory suggests an influence from the German poet Schiller whom the author quotes elsewhere. In a poem by Schiller (*Das Bild zu Sais*) the seeker after truth (not beauty, as here) violates a divine prohibition and is punished with unhappiness or (in another poem) the truth seeker must exert effort to achieve his goal. Perhaps the author is thinking of the pioneers in art, the great originators, who explore new fields.

An enjoyable and constructive chapter is *Digression into Movie-land*, an analysis of the animated cartoon. Here we are showed how the id is given unlimited freedom, because of the large measure of unreality that is present. Still this unreality allows for a full play of vivid emotions to the exclusion of anxiety. How "beauty" is thrown in, through color harmonies, "to conciliate the straight-laced critic" is most pertinent. This whole analysis shows how well a psychologic interpretation can deal with this very contemporary art. If anything, more might have been said of other aspects of beauty besides color that keep adults from losing interest in Mickey Mouse. The repertoire of beauty in the animated cartoon is richer than the author leads one to believe.

Poetry according to the author brings up emotion from the unconscious, preserves the directness and freshness of the emotion, but divests it of its unpredictable, unfettered passion, through its forms, its poetic imagination, rhythm and rhyme and other devices. Music, unhampered by content conveys emotion so accurate, so full and pure as to be quite unobtainable by any other process. Here more than in any of the other arts the id character is effaced.

Primitive dance is self enjoyment, until added ornament indicates a shift from narcissism to others, and also bestows an independent value on the ornaments produced. Original emotions in the dance express and relieve emotional tension at a later stage transferred to the production which continues to serve the purposes of emotional release.

How concepts of beauty have changed can be demonstrated by noting the change that has taken place in man's relation to nature. The ancients cared only for the pleasant aspects of nature where the paternal attitude of the nourishing earth was alone interesting. Now that we have a better grasp and a more realistic attitude toward agriculture, its esthetic value has diminished. Instead we seek out the mountains, and the high sea. Today nature that is wild and awe-inspiring is more to our taste than the tame nature of antiquity.

Of course not all of what is said is new and what may seem vague is not advanced as an ultimate solution. Not all parts are developed with equal clarity, and hints need not be false because they still need to be substantiated. Certainly this book is thoroughly interesting; it has several fresh leads and it should prove stimulating to all those students of the arts who find orthodox esthetics somewhat barren.

NATIONAL GALLERY OF ART
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ERWIN O. CHRISTENSEN

Case Studies in the Psychopathology of Crime, Vol. II. *Ben Karpman, M.D.* Medical Science Press, Washington, D. C., 1947. 2nd ed. revised. \$16.00.

Karpman has played a unique Boswell to criminal patients and produced in his CASE STUDIES IN THE PSYCHOPATHOLOGY OF CRIME a book which will certainly remain unique for a long time to come. The book is practically a stenotype record, verbatim, even without the medium of the third person. These long autobiographic sketches are in the first person, no less, and the question is, how did the psychiatrist secure such lengthy documents when we know that college students outdo themselves when they emote to 2,500 words about themselves. To secure this material the author uses two methods, namely, the conventional psychoanalytic approach, and another method which he designates as "Objective Psychotherapy" or the Questionnaire Method, to the exposition and explanation of which he devotes about twenty pages. One case (No. VIII), studied and treated entirely by psychoanalysis, is given in detail—free association, session by session; the other 3 by the method of objective psychotherapy, which covers the patient's entire life.

Granted that these vast records, given by the patient himself, are entirely subjective, presenting the patient as he sees himself and his relation to others, they are "raw data" in the sense that the patient himself expresses his viewpoint of his life, however distorted or out of

accord with the facts of his life this may be; as such, they are surely highly valuable from a clinical standpoint.

Each of the 4 subjects in the volume was an inmate of St. Elizabeths Hospital, who looks backward over his life and records those things in it which impressed upon him a permanent memory or to which he reacted strongly. In addition, each subject gives a rather elaborate summarization of what he considers his life has meant to himself and others. Preceding each of these vast autobiographic labors is a statement of the police record, of physical examinations, of family background and of other relevant material. These autobiographies, in protocol form, may be dispassionately diagnosed by as many readers as wish to offer an interpretation. Not only is the waking history of the patient recorded; there are pages and pages of dreams. The whole content of the patient's mind as far as it could be captured by such methods is laid forth for review.

In the foreword to the book these endless records are described as "case studies." Actually, these documents could better be described as "film strips," in the sense that the camera sees and records but does not interpret. There is much "interpretation" in the text but it is by the subjects themselves so that this does not alter the essentially photographic nature of these records. The camera was just turned on and allowed to run and hang the footage. These exhaustive compilations are high among the longest and most detailed records of the mental activities of mentally ill criminals, given by themselves, to be found anywhere in the literature.

However, the essence of the scientific method is the arrangement and interpretation of facts. Arrangement and interpretation imply an abstracting out of the vast nexus of events, those relevant to the hypothesis to which we are committed. To return to the film strip analogy, we may think of a correct hypothesis as a stereoscopic principle which gives true relational perspective to data. All too frequently, preoccupation with defending by demonstration a favorite hypothesis leads to the selection of supporting facts and the rejection of disconcerting ones. The condensed anecdotal life-in-a-paragraph "case study" may be taken as an excellent example of this technic at its worst. Far too often in the social sciences, case histories involving the major crimes of a human life are "explained" in a few sentences. Karpman has gone from that ultraviolet oversimplification far into the infra-red by shoveling everything into the hopper of the printing press. The reviewer feels that the first contribution Karpman has made in this book is by giving, through these records, a demonstration of how highly abstract and selective a conventional case history is, and secondly, the demonstration that rich data can be secured from patients. We surmise the third step, explanatory hypotheses for the phenomena presented, will be forthcoming in his next volume.

For as life is relational, human personality is an integrated network of structure and function complexity interwoven on the shifting loom of time and space. The problem of valid interpretation (Karpman's next task) involves the crystallizing out, from the panorama of word pictures this book gives for each patient, of the unique processes of each personality. This the author has not chosen as his present objective. Instead, piling page on page, with great labor and infinite patience, Karpman has, one may say, called the bluff of the facile interpreters who too often reconstruct the skyscraper of total personality on the basis of a few scattered foundation stones. Can we not expect he will now focus on the next step?

Karpman has done a job which, in the long run, may prove to be a base-line for many surveys of the human mind, normal and abnormal. Students are in his debt for performing this colossal task. It is now up to the reader to find his own hypotheses or to induce Karpman to step from the role of Boswell to that of the psychiatrist. His therapy has been notable and he is not inarticulate.

HELEN HALL JENNINGS, PH.D.

SPECIALIST IN HUMAN DEVELOPMENT

INTERGROUP EDUCATION IN COOPERATING SCHOOLS

AMERICAN COUNCIL ON EDUCATION

Experimental Studies in Psychodynamics. A Laboratory Manual and Experimental Materials. *D. W. MacKinnon and Mary Henle.* Harvard University Press, Cambridge, 1948. ix. 177 pp.

This manual, first devised for courses in Clinical and Experimental Psychopathology, according to its authors, is suitable for laboratory work in such fields as Dynamic Psychology, Motivation and Conflict, Psychology of Personality and Abnormal Psychology. The manual, therefore, aims to afford training to college students in conducting experiments designed especially to increase their understanding of human motivation as deduced from intentionally structured situations. Psychiatrists and clinical psychologists not engaged in training programs probably will want to become acquainted with the manual because it indicates a trend in the preparation of future collaborators, whereas those directing graduate students in clinics may welcome it as a supplement to existing procedures.

Fourteen studies, each one usually requiring a laboratory period of four hours' duration, indicate that the program can be completed in a college semester. All of the studies could hardly be completed by an undergraduate student in a college quarter. The nature of each experiment presupposes considerable familiarity with literature challenging to the brightest student, hence the manual readily lends itself to a two-quarter or even a full year course.

The scope of the field represented in the experiments cannot be indicated by a summarizing statement. A reader of this review may find a listing of the experiments together with a statement of the primary aim

of each one the best aid in deciding whether or not the manual meets his instructional needs. Several hypotheses may be tested in each study but I think little if any distortion of the major aim is represented by the following condensation.

OUTLINE OF EXPERIMENTS.—I. *Substitution*. To determine if a substitute will be accepted for an activity which a subject is not permitted to complete. II. *Field vs. Situation*. To discover the effect of changing the meaning of interruption upon the resumption of interrupted activities. III. *Recall of Finished and Unfinished Tasks*. To compare finished and unfinished tasks in recall. IV. *Ego-Involvement and the Recall of Tasks*. To study differences in behavior of tension systems corresponding to activities which involve the ego to different degrees. V. *Forgetting of Tensions*. Will the modification of the context of an intention change the frequency with which the intention is carried out? VI. *Satiation*. To observe the course of satiation and to determine the effects of satiation of one activity upon other activities. VII. *Level of Aspiration*. To determine the influence of success and failure in one set of tasks on the level of aspiration in another. VIII. *Level of Aspiration*. To study the influence on aspiration behavior of the degree to which an activity involves the ego of the individual. IX. *Conflict*. To study the modes of resolution of three basic types of conflict. X. *Repression*. To attempt experimentally to produce forgetting of material wounding to the ego. XI. *Frustration and Regression*. To produce regression in normal adult subjects. XII. *Frustration and Aggression*. To elicit aggressive reactions to frustration. XIII. *Distortion of a Psychological Field by the Needs of an Individual*. To investigate further the influence of unresolved need tension on behavior. XIV. *Myokinetic Psychodiagnosis*. To investigate changes in motor expression after frustration and to discover, if possible, if differences in personality are revealed by this form of diagnosis.

Although it may be concluded that the above experiments can be undertaken in any sequence this is not true. The authors have sought to derive a logical sequence so that as the student progresses through the series he is required to loop back to make contrasts and comparisons. Each study is introduced with a discussion of the problem and this is related to other problems within the chosen field. A desirable feature of the manual is its accompanying exercises. Rarely is an instructor required to provide additional experimental materials and when he is they are usually available as standard equipment in a department of psychology. The *Instructor's manual* shares the authors' experiences in supervising student experimenters. It calls attention to the occasions when he should give them a preliminary briefing which is aimed not only at clarifying technical procedures but also at the problem of proper role-playing by these experimenters. Another useful feature of the *Instructor's manual* is its provision of data collected in the preliminary trying out of the exercises, inadequate as these data must be in a new type of course.

"*Experimental studies in psychodynamics*" is not a manual adapted to large classes or to relatively naïve students in psychology. The experiments put a considerable burden upon the time as well as the skill of the students conducting them. They are called upon to secure their own subjects, who must be psychologically unsophisticated, from a college community and preferably without work in psychology. Infrequently can a subject be used in more than one experiment and even he must swear to secrecy about the procedures, otherwise their aims would suffer defeat. As a rule, those conducting the experiments work together in pairs, alternately serving as experimenter and recorder with 2 subjects. The team of investigators functions reciprocally, supplementing and then correcting each other outside of the immediate laboratory situation. Both are called upon as experimenters to center interest upon the psychologic field or to discover what is the meaning of each situation for the subject. What the subjects say or do must be recorded completely, as objectively as possible, and with awareness of the possibility that the experimenter's bias may select data. Results, conclusions and questions are required in the reports of the experimenters. They are called upon to compare results obtained from their own subject with the data obtained by combining those of all experimenters in the class and, presumably, with the results provided in the *Instructor's manual*. Not all of the emphasis is upon quantitative data for the experimenter is explicitly informed that he must have high regard for behavior which cannot yet be measured, that is for qualitative data. The questions put to him seek to center attention on problems of everyday living as well as upon conclusions more directly contained in the experimental results. Each study is accompanied by references appropriate to the task under investigation even though some of these must defy the capacity of some students to profit from them because they require a thorough knowledge of German.

MacKinnon and Henle undoubtedly have sought to present a carefully formulated program designed to extend the student's grasp of some of the dynamics of human behavior. They have presented the experiments in such a way that with a minimum of guidance by the instructor a selected group of students could carry them out with marked profit to themselves and without giving offense to their subjects. There is a desirable emphasis upon the formulation of hypotheses and the construction of experimental designs to test them. Undoubtedly participation in this laboratory program will do more than acquaint students with concepts covering some of the basic factors in motivation. They will be obliged to recognize that exceptions to neatly formulated assumptions and explanations bear explicit testimony to the operation of many variables not controlled in existing experimental studies. Regarded differently they must achieve a healthy skepticism toward the practice of explaining any segment of human conduct by, the principle historically assigned to it.

The authors of this manual appear to have been too optimistic con-

cerning the clientele likely to profit from the experimental studies. Perhaps these authors have been fortunate enough to have a few, selected students in the courses for which the laboratory manual is said to be suitable. With the influx of students oriented toward clinical psychology, many of whom are college graduates, the conduct of this kind of experimental laboratory demands the time of several, if not many, instructors. How many instructors within a psychology department have the training and conceptual framework to accept responsibility for handling adequately this type of experimental course? How many students are ready before the graduate level to do justice to the rigid requirements of each experiment? These questions are raised not in condemnation of a worthy effort to broaden training in experimental procedures going beyond the typical course in experimental psychology. Their intent is to warn an instructor to observe carefully what demands this course in Experimental Psychodynamics requires him to meet.

Let us elaborate upon a few of them. An instructor and his students must have a firm grasp of the concepts prevailing in the theoretical framework of topological and vector psychology, particularly as enunciated by Lewin. Although MacKinnon and Henle insist that the psychologic language associated with the lewinian variety of field theory is generally understandable, I believe there are those of us, having attempted to acquaint graduate students with the meaning of psychologic fields, relevant fields, inclusive regions in which a tension system is embedded, valence, vectors and the topology of forces operating in a subject's life span, who conclude that neither the language nor the concepts are readily understandable. These and other concepts like them confront the student experimenter. Although most often descriptions and example are immediately appended, at best a student not well-grounded in the topology of a school (apologies to the authors who say the language is independent of schools!) can secure from the manual itself only the minimum limits of the concepts. Much as psychologists might plead with psychiatrists to know the complexities of topology of the lewinian rather than the freudian variety, the reviewer unhesitatingly asserts that the manual limits its appeal to those practitioners responsible for training programs.

Ideally a student should enjoy a wide acquaintance with the theories and methods of psychoanalysis to get the most out of a course such as the one devised. This observation is not original with the reviewer for the authors state that theoretic discussions and even some illustrations issue from the work of psychopathologists, especially from Freud. Since the contributions of psychopathologists have been fitted into a different theoretic framework, any noticeable connection between psychoanalytic concepts and those presented is oblique and almost completely dependent upon knowledge gained outside of this laboratory course. The terms are at times those of Freud (see the list of experiments) cast in a different setting. This again suggests that the student participants need to know the concepts of Lewin and of Freud.

Since each pair of investigators requires a separate room for the conduct of experiments and at least an additional room for subjects waiting to complete a session, the matter of space in overcrowded colleges again dictates a limited enrollment for this laboratory course. The types of subjects to be selected by the experimenters also reinforces the belief that only especially prepared students can meet the conditions of such a laboratory. Without naming the particular experiments we can sketch a few of the personality attributes the subjects ought to possess. In four of the studies the subjects should be lively, energetic and like to do things well; in two other experiments these traits should be combined with going forward with success and yet sensitive to failure. In other experiments subjects should be intro-punitive individuals or again extrapunitive persons who, in addition, should not like the experimenter. Yet again optimists and pessimists must be sought as well as introverts and extroverts. Surely these requirements are difficult to meet. They, too, supplement the conclusion that the manual is actually adapted to a few students who have showed unusual aptitude in assimilating the concepts of psychodynamics and in both experimental and clinical procedures.

It must not be assumed that the exercises in the manual put stress upon the necessity of teasing out the derivatives of drives as would an analyst or psychiatrist. The stress is upon determining how a subject interprets the experimental situations and what changes in his immediate behavior can be assessed to his changed psychologic field. This being so we might justifiably conclude that the manual enables a student to demonstrate certain attributes of forgetting, repression or regression, for example, without actually discovering the dynamic forces underlying the behavior of his subjects. Surely all of the variables are not tapped by restructuring situations and then recording and analyzing quantitatively or qualitatively what occurs within the experimental session. It seems desirable to supplement the proposed methods of investigation by case histories of the subjects, at least, and preferably of the student experimenters also.

The reviewer would consider himself fortunate to have the aid of this laboratory manual in directing a small group of students well oriented in the field of clinical psychology. For such students the manual has most value. As already implied, practicing psychiatrists will find it of interest in so far as the authors have made a serious attempt to capture the designs of experiments which at least invade the area of psychodynamics.

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CHARLES BIRD.

Book Reviews

Pain. *H. G. Wolff, M.D. and S. Wolf, M.D.* Charles C Thomas, Springfield, Ill.

As Number 5 of the new "American Lecture series" published by Thomas (Springfield, Ill.) appeared a small book on "*Pain*" by Wolff and Wolf who in recent years have made valuable contributions to the physiology and clinic of the pain problem. Hardy, Wolff and Goodell developed a quantitative method for the study of cutaneous pain by exposing an area of the skin to radiant heat and determining the stimulus intensity in milligram-calories. They found a remarkably uniform threshold to pain, the deviations among 150 subjects varying only by ± 15 per cent. Two forms of pain are elicited under these conditions, the "burning" and the "pricking" pain, the latter appearing with higher intensity of stimulation. In spite of the constancy of the pain threshold at different times for the same individual and rather insignificant differences in different persons the *reactivity* to pain may vary widely between different persons and also in the same person at different times. As a measure of the reactivity to pain the authors determined the intensity of the stimulus (radiant heat on the forehead) which elicited a marked change in skin resistance (forearm and middle finger). The pain *reaction* threshold is lower in neurotics than in normals. Drugs such as alcohol and morphine which raise the threshold for pain perception increase the threshold for pain reaction several times more. Increasing doses of analgesic drugs such as acetylsalicylic acid increase the threshold of pain gradually until a maximum is reached. Further increases in dosage increase but slightly the duration of the analgesic effect.

The authors discuss briefly the evidence for specific nerve endings for pain and the role of fast myelinated and slow unmyelinated fibers in the conduction of nociceptive impulses to the central nervous system. The latter seem responsible for the transmission of the itching sensation and of burning cutaneous pain.

Doubling the threshold intensity leads to nearly maximal pain in experiments involving radiant heat as pain stimulus. Twenty-two increments between these two intensities can be perceived.

Pain is differentiated from other cutaneous sensations by these facts: (1) it shows no true adaptation; (2) the law of spatial summation is not applicable to cutaneous pain; (3) morphine, codeine and alcohol increase selectively the threshold for pain without altering that of other cutaneous sensations.

The phenomenon of referred pain is subjected to an interesting analysis. Immersion of a finger into water of 0 C. induces spread of pain to the adjacent finger on either side. Anesthetization of one adja-

cent finger does not prevent the spread of pain to this finger indicating that the spread is a central and not a peripheral effect and that the spread does not depend on afferent impulses from the structures subjected to this spread. The spinal origin of the referred pain is clearly showed by the fact that noxious stimuli applied to a leg which is anesthetic on account of unilateral interruption of spinothalamic tracts below D₁ elicit referred pain in the contralateral extremity. Referred pain may occur with or without hyperalgesia and only in the former case does injection of procaine into the hyperalgesic area diminish the pain sensation. The Monograph is concluded by a discussion of the mechanism of the various forms of headache and of the nervous pathways involved in pain originating in the viscera and deeper structures of the extremities. A bibliography of 103 numbers is appended. The problem is obviously not treated exhaustively but physiologists, psychologists and clinicians will read this little book with profit.

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E. GELLHORN, M.D.

Deep Analysis. Charles Berg, M.D. W. W. Norton & Co., New York.

This is an excellent report of the analysis of 1 case. The description of every step in treatment is so thorough that little is left to the reader's imagination. It is a treatment of the subject that has long been looked for by students in the field of psychotherapy who have not been analyzed. Associated with the description of what took place in the course of the analysis is an excellent discussion of theoretic formulations which stand out more clearly because they are illustrated by something which is current in the analysis that has prompted the discussion.

There is a vivid description of transference phenomena and how they can be used clinically towards giving insight into unconscious conflict. In this connection the negative transference and marked unconscious resistance, is clearly described and discussed; and this includes the author's methods of dealing with the resistances. The use of free association, the value of dreams, the way anxiety underlies all symptoms and the compulsive need to repeat infantile patterns, receive careful treatment. The author keeps before the reader at all times the clinical state of the patient, ending with recovery which liberates psychosexual energy sufficiently to permit a heterosexual adjustment. Before this could be accomplished, the patient had to be carried through the reasons for his having developed a homosexual conflict which interfered with the desire for normal mating and produced characterologic difficulties. In this connection there is an interesting description of an emotional fixation on the father behind which lay a fixation on the mother. The discussion of this phase of treatment contains a valuable treatise on the subject of homosexuality.

The subject who is analyzed is an unusually bright individual, so that the discussion that goes on between the patient and the analyst is on a higher plane than would be expected in the average run of cases. Occasionally statements are made that are not proved, and remarks are made to the patient for reasons that are not made clear, but in the main the book is easy to follow step by step. It is obvious from the above that this reviewer recommends this book as a valuable addition to the literature on psychoanalytic therapy.

AMHERST H. WILDER CHILD GUIDANCE CLINIC
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H. S. LIPPMAN, M.D.

An Introduction to Physical Methods of Treatment in Psychiatry.
W. Sargant and E. Slater. The Williams & Wilkins Co., Baltimore,
1948.

This is a well written practical guide in those forms of treatment in psychiatry which involve physical and chemical methods. After an introduction into the principles of a rational therapy the main groups of shock therapy are discussed in their technic, indications and statistical results. Combination of electroshock and insulin treatment was found effective in cases in which either method applied alone had failed. A convulsive fit induced at light coma "is milder than when given in the fully conscious state, and is succeeded by immediate and deep relaxation". Up to ten convulsions are recommended during five to six weeks in insulin treatment. The modified insulin treatment (in sub-convulsive doses) "has a powerful effect on anxiety and tension, and is often a better sedative than the barbiturates, even for excited psychotic patients". In the discussion of convulsion therapy it is mentioned that intravenous injection of sodium amytal may induce a state in the patient which is similar to that accomplished by repeated electroshocks. It serves therefore as a convenient test in schizophrenics and other mental groups. In the chapter on treatment of epilepsy by D. Hill the role of afferent impulses and of emotion in the precipitation of fits is stressed. Different forms of emotional stress are believed to play quite different roles as the following quotation suggests. "Reports on the incidence of fits during air-raids showed no increase, suggesting that fear, anticipatory tension and anxiety are not relevant emotions. On the other hand, it is common experience that emotions such as frustration which involves the adrenal-sympathetic system tend to precipitate seizures." This reminds one of observations of Wolff and Wolf who found different somatic effects on vascularization and secretion of the gastric mucosa as the result of various forms of emotional disturbance. The beneficial effect of benzedrine in the treatment of behavior problem children is emphasized and a brief but clear description of the modern methods of narcosynthesis and excitatory abreaction (induced by ether) is presented. This is a very useful book for prac-

tioners. However, the reviewer regrets that very little use is made of the basic concepts which underlie the various forms of therapy described in this book.

E. GELLHORN, M.D.

Studies in Criminology. *Arthur N. Foxe, M.D.* Nervous and Mental Disease Monographs, 1948. 162 pp. Cloth \$4.50.

The book consists with few exceptions of a series of previously published articles by the same author. Some of these date back to 1936. Some of the material was delivered before lay groups and is very elementary. None of the articles is long or extensive. While the author divides the book into three parts, general, classification and psychoanalytic, there seems to be a motley grouping of subjects that have very little relationship to any psychiatric study in criminology unless one takes a rather broad view of the study and includes historic and other material. For instance, in the general group there are chapters on witchcraft, delinquency and epilepsy and in the section on psychoanalysis there is an article on "Terrorization of the Libido and Snow White". The reviewer feels that this book is really mislabeled and should have been called studies about criminology and even then it would have been a generous title. On the whole, the book is rather hard reading and does not warrant the time it would take for any one except those who may want parts of the book such as the part on classification. The studies the author relates were in the main with those who have been convicted of crime. The reviewer agrees that the same basic psychiatric difficulties occur in others, the difference being that some of the unfortunates have not been "convicted of their acts". There are quite a few statements that one could take exception to in this book, particularly if no further information is available than is given in some of the cases. On the whole, this book is not recommended for the general physician and is only of limited value to the psychiatrist who desires to further his knowledge in the psychiatry of criminals.

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PHILIP LITVIN, M.D.

The Metabolic Brain Diseases and Their Treatment in Military and Civilian Practice. *C. T. Stockings.* Williams & Wilkins Co., Baltimore, 1947.

This book is based largely on clinical studies in military practice. The importance of this type of material is emphasized. Clinical evaluation of therapeutic procedures is not complicated by secondary factors (mental degeneration and other diseases) frequently occurring in chronic hospitalized patients. The author attempts a functional classification of mental diseases based on the analysis of the therapeutic effects of the different forms of shock therapy. He distinguishes two forms of metabolic encephalopathy, the dysoxic and the dysglycic forms. This

classification is based on the fact that the former responds to anoxic therapy and the latter to treatment with insulin coma. Although the reviewer is in general agreement with the author that through the physiologic analysis of the procedures of shock therapy important conclusions can be drawn about the nature of the mental illness (cf. Gellhorn, *Autonomic Regulations*, N. Y. 1943, p. 287ff) he questions the soundness of the information of the author in fundamentals of biochemistry and physiology. Convulsive therapy is identified with anoxic therapy, while hypoglycemic therapy is said to attack mainly glycolyzing cells and glycolyzation processes. The former interpretation is contradicted by the author's own statement that the method of inducing anoxia by means of N_2 inhalation although diminishing the O_2 saturation of the blood to a greater degree than is seen in electroshock "is clinically less effective than the electroanoxic fit." There is no evidence in the scientific literature that the processes of oxidation and glycolysis are carried out in the brain by different cells. Moreover, anoxia therapy would greatly intensify glycolysis and treatment with insulin involves both glycolysis and oxidation. In spite of the basic defects in the author's theory the book provides some valuable information if read with sufficient criticism.

E. GELLHORN, M.D.

Abstracts from Current Literature

Psychosomatic Aspects of the Korsakoff Syndrome. G. W. Davidson, *Manhattan State Hospital, Ward's Island, N. Y.* Psychiat. Quart. 22:1-17, January 1948.

Eight Korsakoff patients were submitted to sodium amytal interviews to ascertain the extent to which personal material could be obtained to explain memory difficulties, especially as regards confabulation. These patients were examined upon admission, on the day before the treatment and while under sodium amytal. Each patient received 4.5 to 6 grains intravenously. There were no untoward symptoms and none fell asleep or became drowsy. Their speech became thick within fifteen minutes of commencing the injection. Interviews under narcosis lasted about an hour. The patients appeared to sober up for about a half hour during the interviews and showed a considerably improved memory during that time but returned to their confabulatory amnesic state when the interviews ended.

Several case histories are presented, the patients showing the following traits under sodium amytal. The clinical syndrome was unchanged in 3 and grossly reversed in 5 cases. Euphoria changed to irritability, aggression and belligerency in the reversal cases, while their speech became spontaneous, amnesia lifted to a varying extent, and there was no confabulation. The original syndrome persisted in the

other 3 cases. Attachment of the patient to and dependence upon the father was ventilated in all cases. The sense of dependence could be transferred in later years to the army or other figures. Married patients occasionally or persistently denied marriage. Indifference was expressed toward women, neither overt nor latent homoerotic tendencies were seen and libido was passive. An amnesic level could be established, some critical experience such as marriage, being a repressed traumatic experience marking onset of spread of the amnesia. Islands of memory were sometimes preserved.

Relationship of the sodium amytal findings with the conclusions of Korsakoff are discussed and the mechanism of the syndromes outlined by applying the concept of the final common path of the total personality. Affectivity is expressed as euphoria when the syndrome crystalizes itself out and inner actualization stops. Euphoria changes to irritation and aggression when reversal occurs under sodium amytal, inner actualization is revived and patients become spontaneously productive. Certain changes in affectivity of the Korsakoff patient have been known but not properly evaluated in the past. A veil of anterograde amnesia is drawn over the stream of consciousness when affectivity is suspended and inner actualization ceases. Any external stimulation produces compensation marked by quick repose with past confabulations. Relationship of emotions to neurologic structures are discussed. The mammillary bodies are considered important to the Korsakoff syndrome.

Strychnine sulfate grain 1/30 every three hours for two days was helpful. Vitamins B and C should be given with other physical methods indicated. Proper understanding of the psychotherapy for both prevention and improvement. Sodium amytal interviews may be of assistance in this. 23 references.

Psychotherapy in a Veterans Administration Mental Hygiene Clinic. *Nathan Blackman, St. Louis, Mo.* Psychiat. Quart. 22:89-102, January 1948.

Modern living tends to prolong the period of human dependence, often into adult life, and to produce an adult existence often lacking a sense of accomplishment or purpose of attainable goals. Military service tended to prolong this dependent period in veterans, while they developed self deception and a feeling of importance. Group solidarity and strength are lost when out of the service, extent and acuteness of symptoms manifested during readjustment depending upon the extent of ego-regression incurred while in the service. The mental hygiene clinic attempts to fully evaluate individual problems of the veterans and assist them in bridging the gap toward normal civilian life. Effort is made to give them a perspective and a secure evaluation of their needs by a thorough uncovering and re-synthesis of individual emotional

conflicts, and to re-assess and remedy weak points in the patient's defenses.

Individual and group treatments were combined in the clinic in order to provide a situation through which a re-synthesis of social cognizance and a desensitization of daily problems could take place. Members of the group were urged to verbalize their problems and take active parts in the discussion. Groups usually had 8 or 10 members and held weekly meetings lasting one or two hours each. A feeling of cohesiveness and spontaneity of common interest gradually developed. Many subjects were discussed at meetings, such as individual service experiences, childhood recollections, dreams, the Negro problem, religion, economic opportunities, newspaper headlines, etc. As expressed by patients, these meetings produced individual confidence by giving a feeling of being one of many, of whom the individual felt he could do as well or better than any. Scared individuals unable to accept the chaos and inconsistencies of daily life found a benevolent, secure and understanding situation, and understanding and forgiving father-figure. Their efforts at expression or assertion became permissive and easy to bring out. They learned to concentrate on the objective. A gradual desensitization toward unfamiliar figures of civilian life was carried out. The patients not only verbalized their life experiences but lived, acted and expressed gradual reorientation toward life as it is. Ability for self deflation and self assessment without hurt was established. The veteran was made to feel that life outside himself continued and wanted his aid. The important consideration was that these men needed help in becoming identified and in learning how to hope and strive like others. Veterans Administration, community, social and religious resources were all utilized with encouraging results in over half the cases treated. A tabulated statistical study of 100 consecutive patients is presented. 1 table.

Clinical Investigation of Simple Schizophrenia. *Otto Kant, Worcester State Hospital, Worcester, Mass.* Psychiat. Quart. 22:141-51, January 1948.

A group of simple schizophrenics is analyzed as regards heredity, personality makeup, clinical picture, onset and dynamics of schizophrenic development. Remarkable differences were found between the clinical picture of this group and that of simple schizophrenia given in text books. The factor of disintegration was found in all cases. Severe loss of contact was found in 7.8 per cent and fair loss of contact in 21.8 per cent of cases. Many of the remainder were surprising in their excellent contact with surroundings. On the other hand, queer-ness or disintegration of personality was present in 60.9 per cent of cases.

Age at onset of symptoms was doubtful and varied from 12 to 40 years. Schizophrenic changes occurred gradually in 96.7 per cent of cases. There was evidence of hereditary tainting with various types

of hereditary psychoses in 61.9 per cent, schizophrenia being much the largest single group. Hereditary tainting was reported in nearly 70 per cent of 1,000 cases by Kallmann. Prepsychotic personality changes were present in at least 50 per cent of patients, personality characteristics present according to percentages being lack of sexual adjustment 98; lack of aggressiveness 87.2; introversion 70; reaching out for contact 64.8; predominantly leptosomic physique 60.4; shiftless workers 60; subnormal intellectual functioning 51.5 per cent. All but 1 patient had failed to make normal sexual adjustment and he had had various heterosexual affairs though no lasting attachment. Lack of sexual adjustment was therefore considered really important in all cases.

This investigation showed that the inconspicuous simple type is most characteristically schizophrenic as to heredity, personality make-up, early environmental situation, and failure to shoulder normal responsibilities. The simple schizophrenic patient shows some tendency toward withdrawal but is in much better contact with reality than other schizophrenics. Disintegration seems more fundamental than withdrawal which may be considered a secondary reaction. Presence of disintegration during all stages proves that the usual understanding of simple schizophrenia as simple withdrawal or unresisting acceptance of inferiority does not express the essential psychologic happening. There were four groups of dynamic features most easily observed in the simple type. The prepsychotic picture is characterized by lack of sexual adjustment and normal aggressiveness but attempts at aggression and sexual indulgence are prominent during the early schizophrenic period when the id can actually be observed. These urges now seek fulfillment but on a primitive level such as attempted sexual, sexual play with children, exhibitionism, aggressive assault and property destruction. Comparing simple schizophrenia and neuroses, the dynamics in the former show a disintegration of the personality superstructure leading to infantile attempts at realization whereas in neurosis there is a conflict between instinctive urges and super-ego. There is a parallel however between the characteristic indecision of neurosis and the basic ambivalence of schizophrenia. The latter is a disintegration of the personality and individual functions. Characteristic dynamic features are a pre-psychotic lack of assertiveness and disorganized early home environments which were unsatisfactory models for development of the ego. One of these was present in every case of this series. 8 references. 3 tables.

Convulsive Disorder and Personality. *Edith Silverglier Lisansky, Yale University, New Haven, Conn.* J. Abnorm. & Social Psychol. 43:29-37, January 1948.

Theories about epilepsy seeking to account for the personalities developed by epileptic individuals are examined. Implicit in most theories, except those that are termed stress and psychosomatic theories,

is an assumption that there is a typical and fixed epileptic personality. It may be said that the weight of evidence is against the existence of a typical and fixed personality which characterizes all or even most epileptic patients. Studies of noninstitutionalized, nondeteriorated adult patients using projective personality tests are lacking. Two groups of sick adults, epileptics and diabetics were compared on a battery of psychologic tests. Significant or near-significant differences emerge in mean Wechsler-Bellevue performance IQ (diabetics are higher) in average time per response on the Rorschach (epileptics are slower), and in average number of neurotic signs on the Rorschach (epileptics show more neurotic signs). On the Rorschach the epileptic group shows more emotional strain and less acceptance of self than does the diabetic group. Among the epileptic subjects, nearly all of whom developed epilepsy in adolescence or adulthood, there is a clear trend toward greater maladjustment. On the whole, however, the groups show far more similarity than difference. On the Rorschach drive for achievement both groups show but limited productivity, tendencies to construction and withdrawal, and conflict in their tendencies to be outgoing and to withdraw. The small number of cases permit only of limited generalizations. The present data, as far as they go, do indicate that there is no typical personality picture which characterizes the epileptic group and distinguishes it from other sick or neurotic groups. 17 references. 5 tables.

"Playing the Dozens". A Note. *Cornelius L. Golightly, Olivet College and Israel Scheffier, Brooklyn, N. Y.* J. Abnorm. & Social Psychol. 43:104-105, January 1948.

The "dozens," played among Negroes, is one form of "talking" recreation often engaged in by rural boys. It is usually played by two boys before an appreciative, interested audience. The object of the game is to speak of the opponent's mother in the most derisive terms possible. Many boys know long series of obscene ditties and verses concerning the immoral behavior of the mother of the one they are "putting in the dozens," and they sometimes recite for hours without interruption. The game usually ends pleasantly. While it is true that the behavior is a fine example of formalized expression of aggression and that in the absence of anything better to do, it serves as entertainment, it is also psychologically significant that such behavior indicates deep pools of frustration and an appalling paucity of recreational outlets for Negroes in our culture. 4 references.

Limitations of the Scapegoat Theory of Prejudice. *Bohdan Zawadzki, College of the City of New York, New York, N. Y.* J. Abnorm. & Social Psychol. 43:127-41, April 1948.

Basic principles with regard to the problem of group prejudice are discussed. The obvious defects of the popular well earned reputation theory of prejudice, in conjunction with some nontheoretic reasons,

moved the modern social psychologists to construct a more satisfactory theory, namely, the scapegoat theory. According to it, group prejudice, like any other hostility, is a reaction not to an external stimulus; but to an internal process-frustration. No matter what are the sources of frustration, the accumulation of frustrating experiences generates aggression. The hostility which at first seems to be free floating, without any specific object, often finds (or perhaps seeks out) a suitable object and becomes directed toward it and attached to it. Often such an object offers itself, not as a single person, but as a whole group of people, when such a group is a minority living within the majority of which the frustrated and embittered person is a member. And this group hostility is rationalized by blaming the innocent minority for frustrations, failures and misfortunes; by projecting one's own feelings of guilt, anxiety and unacceptable traits on the minority; by stereotyping, i.e., treating all members of the minority alike.

While the well earned reputation theory is a pure stimulus theory, the scapegoat theory is a pure drive theory. Both these theories are monistic, one-sided and therefore unsatisfactory. A complete theory of the origin of prejudice must be a dualistic, convergence theory which would take into account both the internal factors within the individual and the objective characteristics of the stimulus. Not only is the scapegoat theory inadequate but it should be exposed because it constitutes a definite danger from the educational and social policy points of view. For the theory goes so far as to deny the existence of group characteristics or at least to deny that they have anything to do with arousing prejudice. Further, the scapegoat theory is harmful to just those minorities it is meant to protect, because it reassures them of their innocence and invites them not to scrutinize their own behavior. It antagonizes unduly those whom it purports to convert, encourages the do nothing and wait for the millenium attitudes and demoralizes the minority into self complacency, if not arrogance. A scientific study of group characteristics is urged, and where undesirable characteristics are found, it should always be with the proviso that these are not racial, innate, but are acquired during each individual's life-time, that is, they are learned and therefore may be unlearned, if not in the present then in the next generations. 10 references.

The Nonmedical Psychotherapist. A Critique and a Program. Benjamin Brody and Alan L. Grey, *University of Chicago, Chicago, Ill.* J. Abnorm. & Social Psychol. 43:179-92, April 1948.

A psychoclinical training program is outlined. Especially emphasized is the importance of building training around actual experience and the need for careful individual supervision of students in their internship experience. Many essential skills such as observational technics, scientific attitudes and operational understanding of rough therapeutic generalizations cannot be entirely communicated on the

verbal level. Close contact with students and their adaptation to real problems—research, diagnostic, therapeutic, affords a far better measure of competence than do answers to test questions. The prime criterion of course-content is its usefulness to the psychoclinician in the performance of his functions. A curriculum would include material from cultural anthropology and sociology, for an understanding of the range of human living patterns and the relationship of such patterns to personality. In the important area of psychodynamics current theories would be examined in relation to each other and to the factual evidence. For the evaluation of facts and hypotheses, and the scientific advancement of their profession, students need training in research methods. In the clinic the student should have opportunity to understand the normal as well as the abnormal. There is every indication that diagnostic and therapeutic competence calls for familiarity with both psychologic and organic factors. The psychoclinician should have enough familiarity with the organic to screen out medical cases and refer them to appropriate practitioners. Consideration of the public welfare indicates another innovation: the maintenance of uniformly adequate professional standards. This requires a system of licensing, legally enforced. 26 references.

Hermann Goering, Amiable Psychopath. *G. M. Gilbert, Princeton University, Princeton, N. J.* *J. Abnorm. & Social Psychol.* 43:211-29, April 1948.

An account is presented by a prison psychologist at the Nuremberg trial of the Nazi war criminals of Goering's early development, his career as a young militarist and revolutionary, his position as number 2 Nazi, and finally his trial and death as a war criminal. By early adolescence the essential pattern of Goering's personality was already apparent: aggressive egotism which found its most desirable expression in the militaristic prerogatives of his culture, enhanced by a rich and vivid fantasy life which sometimes blurred the distinctions between reality and fancy; a tendency to domination of the environment with a combination of fancy dress showmanship and brute force; an emotional insensitivity and perverted humor which were at once the seeds of outward physical boldness and moral depravity. His sense of values were also pretty well fixed by this time, being drawn from the cultural complex by his early indoctrination and personal inclinations: a deeply rooted sense of loyalty and obedience to the sovereign figure of the Kaiser; a sense of the in-group loyalty and solidarity of the German *Volk* with chivalrous hostility toward all members of outgroups; an aristocratic anti-democratic bias which recognized inferior superior groups and the authoritarian militaristic hierarchy. Goering never outgrew the uninhibited acting-out of these infantile ego-drives. He was the typical psychopath. Goering's motives in joining the Nazi Party were quite uncomplicated: it sounded like a good chance to

satisfy his aggressiveness, greed, status-strivings and militant nationalistic ego-involvement all at once. There is perhaps an additional explanation on a psychodynamic basis. After the defeat and flight of the Kaiser, his essentially infantile emotional dependence was left without an authoritarian figure to cling to. In Hitler he recognized such a potential figure. By his final dramatic gesture this amiable psychopath kept the way open to achieve the supreme goal of his life-long fantasies: to get his picture into the German history books—either as a “great man or a great criminal”, depending on the cultural values that emerge out of the civilization he helped to destroy.

The Use of Phonograph Records for the Induction of Hypnosis. Elton B. McNeil, University of Michigan, Ann Arbor, Mich. and Paul Sparer, Harvard University, Boston, Mass. J. Abnorm. & Social Psychol. 43:546-47, October 1948.

Phonograph records were employed successfully to induce hypnosis in 21 out of 24 undergraduates. The criterion of hypnosis was taken from Lecron-Bordeaux scoring system for indicating depth of hypnosis. It was found to be unnecessary to use the records for more than one session with each subject since hypnosis could be induced rapidly by the experimenter in the second session. The transfer of control of the trance state from the records to the operator was successful with all the hypnotizable subjects. Because of the generalized content of the records, this technic might be effective in group as well as in individual inductions. On two occasions 2 subjects were hypnotized simultaneously with these records. Experimentation with hypnosis is greatly facilitated by the use of hypnotic records since, employing transfer records, any experimenter can assume control of the trance state without being involved in the time-consuming induction which is usually necessary. With the hypnotic procedure thus standardized on the records the depth and effectiveness of the hypnotic session can be ascertained accurately for each individual subject since each is exposed to an identical procedure. With careful planning, any experimenter should be able to make a set of records for use in hypnotic research. 1 reference.

Schizophrenic Speech and Sleepy Speech. Alexander Mintz, College of New York, New York, N. Y. J. Abnorm. & Social Psychol. 43: 548-49, October 1948.

Two bizarre utterances of normal subjects about to fall asleep or while awakening are discussed. A plausible meaning was found for each of these statements, though they may have had an additional meaning. Though expressed in the diffuse and incomprehensible fashion characteristic of schizophrenics, the meanings elicited appeared to be quite reasonable. The results support the view that sleep and schizophrenia are related phenomena, and that schizophrenic thinking is within the behavior repertoire of the normal individual.

Motivations of a Murderer. *James E. Greene, University of Georgia, Athens, Ga.* J. Abnorm. & Social Psychol. 43:526-31, October 1948.

At the trial of a Negro, who shot and killed the driver of a car in which he was hitch hiking, the court was given a diagnosis of constitutional psychopathic inferiority. From fairly extensive and seemingly fairly valid data, the following clinical picture of the personality structure of the defendant has been reconstructed. Examination of the defendant's early history revealed the beginnings and gradual evolution of a profound and fundamental pathologic derangement of the personality structure which would not be observable by ordinary inspection but which, if the patient had never seen military service, might still have enabled him to make a reasonably satisfactory adjustment to society throughout his entire life. It is believed that his service experience tended to bring about a partial disintegration in a personality which was already poorly integrated and in which very strong and unconscious aggressive impulses were held in leash only with the greatest difficulty. Next in importance to the unconscious motive of wishing to harm his family, the defendant was most strongly motivated by a need for punishment. It is inferred that the defendant had been actuated for years by a sense of guilt because of his deep-seated hostilities towards his family whom he had been taught to love, cherish and respect. It would seem that the apparently unmotivated attack on the deceased grew out of unconscious aggressive impulses towards the father. The theft of the car and of a suit of clothes, it is held, cannot be considered as being in any sense primary motives for the crime. If the defendant had consciously sought to secure inevitable punishment, with his limited mentality, he could hardly have planned his pattern of behavior with more deliberate cleverness. In the light of the defendant's history of pre-service adjustment, it might be plausibly assumed that, had he been rejected as mentally unfit for military service, he might well have made a reasonably good, or at least a noncriminal, social adjustment during his span of natural life.

Psychopathic Personality as a Genetical Concept. *T. O. Slater, The National Hospital, Queen Square, London.* J. Ment. Sc. 94:277-82, April 1948.

The single causes of profound modifications of the constitution and personality are unable to account for the greater part of human variation in the temperamental field. For this, as with intelligence, it is believed that we must go to the genes of small effect, to the total genetic make-up as the principal known source of a sufficient degree of variation. There is a considerable body of direct evidence that total genetic make-up is of great significance for personality. While the evidence from twins reveals nothing about the nature of the genetic equipment involved, whether it is dependent on one or many genes,

there is evidence of a different kind which shows that we are not here concerned with the operation of single genes of large effect. It has so far proved impossible to discover discriminant factors which will separate cleanly from one another the hysterical and the nonhysterical, the anxious and the phlegmatic, the obsessional and the unobsessional. Wherever the issue is encountered what are found are normal distributions and differences in degree. Furthermore there is the factor of nonspecificity. When the relatives of neurotics or psychopaths of any particular kind are investigated, there is found not only an excess of personalities with abnormal reactions of an exactly similar kind but also an excess of those showing abnormal reactions of different, although to some degree related kinds. It is believed that the evidence is already strong enough to allow us, while accepting the importance of heredity, to reject the single gene hypothesis and to adopt that of multifactorial inheritance. Such a view leads to a more comprehensive and balanced view of neurosis and psychopathy than is the case at present. Above all it avoids a static view of the personality, where all is regarded as rigidly set and beyond the possibility of exterior modification. 5 references.

Delinquency and Epilepsy. A Clinical and Electrophysiological Note. *R. Sessions Hodge, Somerset County Council, Somerset, England.* J. Ment. Sc. 94:439-43, April 1948.

In an attempt to study the evidence required to answer questions relating to a person's knowledge of what he was doing at the time of committing an antisocial act, one hundred and forty records of persons of all ages and both sexes were reviewed. The subjects had been referred for examination following an antisocial act varying in gravity from being beyond control to attempted murder. Careful study was made of the electroencephalographic records of these persons under conditions of rest and stress. Attention was directed to those cases which could be considered epileptic; firstly those on clinical grounds, secondly, those on biochemical grounds, and thirdly, those on electrophysiologic grounds. Figures are presented which make it appear that the members of this series were subject to episodic disturbance being in the nature of widespread cerebral dysfunction which at some point disturbs cortical integration. This disturbance may be related to consciousness and can amount to a diminution, clouding or loss of consciousness. If an accused person is found to exhibit such phenomena, it should be possible to infer that "at some material times" he was in such a state as "that he did not know what he was doing." It would be improper at this stage to speak of an epileptic record save with the reservation that the nature of epilepsy is not yet understood, and that lacking the evidence of a seizure, it is possible only to state the nature of the electroencephalographic finding and await their association with other morbid phenomena. 1 table. 3 plates.

The Community and the Aggressive Child. *J. D. W. Pearce, Institute for the Scientific Treatment of Delinquency. J. Ment. Sc. 94: 623-28, July 1948.*

A child has three main methods of expressing his aggression upon the community. The first is truancy and vagrancy. Truancy is essentially an aggressive act in that it is a positive rejection of the demands and requirements of the community. The very fact of truancy may lead the community to perceive its mistake, and by rectifying this the child's problems may be remedied. As for vagrancy, the community usually insists that the child return to the intolerable situation, to which he then either submits, whereupon the community feels that it has won; or he runs away again, whereupon the community feels it has failed. The second main antisocial technic employed by the aggressive child is stealing. Nearly all stealing habits start in childhood, and it is near the truth to say that if children did not learn to steal there would be few adult thieves. Too often the community is vindictive or, at least, unintelligent. The aggressive child's third technic is by directly aggressive conduct, which extends from bullying, damage to property, the spreading defamatory rumors right up to murder. Usually there is no secondary mental mechanisms involved; the conduct represents a direct outpouring of the aggressive instinct, which in no way puts the super-ego out of countenance. In thinking about the relationship between the community and the aggressive child, one is apt to devote too much time to the problem of helping the already established delinquent child. Far more good will accrue to society if the psychiatrist will look further ahead, and will see the problem as one of positive mental health by helping to uncover and to devise remedies for the social diseases which permit or encourage such unproductive aggression. 6 references.

Color Denial in the Negro. A Preliminary Report. *Henry J. Myers, St. Elizabeths Hospital and Leon Yochelson, Georgetown University Medical School, Washington, D. C. Psychiatry 11:39-46, February 1948.*

The influence of race prejudice in American society on Negro psychotics is discussed. Review of almost 1,000 Negro psychotic cases showed that delusional material involving denial of color and ancestry was not uncommon. White prejudice has placed the Negro in this country in a caste system as rigid as that of India. Stereotyped notions of the white race about the Negro affect community standards, the white ideals being frequently adopted as desirable goals. Caste members tend to develop a distinctive psychology. The Negro suffers certain systematic disadvantages as a result of his socially stereotyped caste position. He develops frustration as a result of his theoretic free and equal membership in American society and his actually belonging to an inferior caste. The Negro has accepted the white's unflattering ideas to such an extent that color consciousness and distinction are important

in the Negro community, more opportunities being provided light people than dark. Whiteness represents increased advantages, achievement, increased self esteem and security. The difficulties of Negro living are therefore increased by the attitudes of both whites and Negroes so that he becomes chronically anxious. This may lead to servility, aggression or even frank psychosis. Individual security operations become of great importance. The desire for whiteness finds expression in the use of skin lighteners and hair straighteners, in dreams and phantasies, in the light skinned Negro passing himself off as white and in psychotic reactions. The latter frequently include elements reflecting his endeavor to solve the color problem and difficulties in living as a Negro. Illustrative case histories are presented. 27 references.

The Role of the Parent in Psychotherapy with Children. *Hilde Bruch, New York, N. Y. Psychiatry 11:169-75, May 1948.*

Child psychotherapy involves treatment of the parent as well as the actual patient. The parents are often the real problem, seeking aid for their difficulties in raising children, their anxiety guilt, annoyances and disappointments about the child's symptoms. It was formerly insisted that parents refrain from any interference with analysis of the child but it is now recognized that parental inadequacies were often expressions of their own personality conflicts and not malice or ignorance. Treatment of the mother was considered a necessary auxiliary procedure but was usually done by a social worker while the psychiatrist took the child. Through force of circumstances, the psychiatrist began to see both parents and child. The decision to seek psychiatric aid often indicates an important change in the parent's attitude toward the child. Evaluation of the parent's attitude toward psychotherapy does not necessarily remove all treatment difficulties. Some parents frankly object to psychiatric treatment while others deny the existence of difficulties and object to any inquiry about family problems. Others have appreciated the child's abnormality for some time but request treatment only because of outside pressure or because they are conscientious and would not miss any opportunity even though they do not believe in psychiatry. Direct analysis of the parental attitude in these cases may cause a successful constructive cooperation. It is important to evaluate the parental attitude which many parents bring to psychiatry. Emphasis on the initial contact however does not indicate that working through of the interpersonal attitudes and difficulties are not equally important. The attitude of child psychiatrists towards parents has changed. A child cannot be successfully treated if his parents are not respected. The present psychiatric attitude towards the problems of parents makes more lasting cooperation possible. Good relationship with parents cannot be obtained if the therapist acts as though parents were hateful, only the child being free.

Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy. *Frieda Fromm-Reichmann, Rockville, Md. Psychiatry* 11:263-73, August 1948.

Psychotherapists formerly considered schizophrenic states as untreatable because there seemed to be no way by which they could communicate with the patient. Changes in psychoanalytic technic were then developed which involved the doctor-patient relationship and the approach to the contents of psychotic communication. After relationship with the patient is established, treatment is continued with as much acceptance, permissiveness and as little rejection as possible, actual destruction or suicidal action being the only things prohibited. Effort is made to establish a consensus with the articulate schizophrenic about his need for treatment and its reasons. The psychoanalyst acts as participant observer guiding the patient into collaborative efforts at understanding until he attains insight. Psychoanalytic knowledge of the potential meaning of schizophrenic production is important for a therapeutically useful interpersonal exchange between analyst and patient. Endeavor is made to help the patient become aware of and understand repressed thought and feeling.

Attention is now focused upon the genesis and dynamics which determine contents of schizophrenic production. Special attention is paid to present timing and circumstances, original setting, precipitating factors and bodily and emotional symptoms preceding or accompanying psychotic manifestations. Even though the patient is too disturbed to actively participate, this has been helpful if the analyst tries to communicate his efforts to the patient until he is able to follow. Much valuable time is lost by waiting until the patient appears ready for active therapeutic moves. They may require numerous repetitions but should at least be started. Only a single therapeutic suggestion at a time however may be offered the schizophrenic with slowed and narrowed thought processes, a second not being offered until there is evidence that the first has been heard. Therapeutic moves likely to cause manifest anxiety must be cautiously offered in order to prevent anxiety turning into panic.

Every psychotherapist, especially those working with schizophrenics, must clearly understand his part in the psychotherapeutic process. He must know how to listen and elicit data from the patient. The aloofness of the schizophrenic must not be interpreted as a sign of personal resistance against the analyst. He must understand that normal minded persons cannot understand what the disturbed schizophrenic communicates and understands. He should not expose himself to violence by the patient, both for his own protection and the patient's self respect. It is important that the psychiatrist maintain a stable and serene state of mind, as his counterhostility or anxiety will blind him in therapeutically evaluating the patient's experience and also make the patient more anxious and hostile. Constructive reassurance is helpful but uncalled for reassurance of the patient is a handicap. Recovery for these pa-

tients does not usually include a change to another personality type. The importance of training the psychotherapist to recognize and control his own dissociated feelings and motivations and in overcoming his own insecurity before working with schizophrenic patients is emphasized. Many treatment failures result from the therapist's inability to adequately handle the mutual interpersonal problems of the patient and himself. 42 references.

Observations Concerning Typical Anxiety Dreams. *Irving Harris, Institute for Juvenile Research, Chicago, Ill.* Psychiatry 11:301-309, August 1948.

Typical anxiety dreams are those of falling and dreams of the nocturnal burglar. Individual differences in their occurrence and comparative unpleasantness are discussed and a preliminary and tentative hypothesis concerning these differences proposed on the basis of certain clinical data. About 90 per cent of 560 men interviewed described their most disturbing anxiety dream as one in which they themselves were in some danger, the two chief dangers being falls or being attacked. Interviews with 2,000 more persons showed that 40 per cent had falling dreams and 39 per cent attacked dreams. Of the remainder, 19 per cent denied having either type of dream and 2 per cent had both types. The falling dream predominated in 38 per cent of military personnel and the attacked dream in 47 per cent. Children had 23 and 58 per cent and mothers 36 and 50 per cent respectively. Only 2.2 per cent of these persons were still having these dreams at least once a year and only 0.6 per cent once a month. There are two psychic dangers in early childhood apparently analogous to these two types of anxiety dreams. These originally emanate from the parents, certain clinical data indicating that people having predominantly falling dreams behave as if fearing loss of love and support while those with predominantly attacked dreams fear castration in its most general sense.

A preliminary hypothesis involving two psychic threats described by Freud is proposed. It is believed that children with predominantly falling dreams would direct conscious hostility toward the father because mothers are usually the source of love and support during the first two years of life. Children with predominantly attacked dreams would direct overt hostility toward the mother because they fear castration by the powerful father. It is believed that information concerning a person's predominant anxiety dream may be helpful in the diagnostic psychiatric interview. Predominance of the falling or attacked dream might indicate the chief psychic threat operative in a particular person. It is suggested that the systematic and routine elicitation of the occurrence and comparative unpleasantness of these dreams might be useful diagnostically. Observations indicate that persons differing in their predominant anxiety dreams have differences in personality or ego maturation. Additional intensive and extensive work is needed to substantiate and refine these suggestions. 5 references.

Character Types. *Israel Newman, Augusta State Hospital, Augusta, Me. Am. J. Psychotherap. 2:372-82, July 1948.*

The accepted terminology and concepts of character types are re-examined in the light of current clinical experience. Jung's classification of introverts and extroverts are inapplicable to the neurotic and the hysteric. They fail also when they are used in the interpretation of those extreme conditions upon whose features they are based—dementia precox and manic-depressive psychosis. To which category does the patient who will have alterations of depression and elation for the rest of his life belong? Nor does Jung's formula apply to the schizophrenics as a group. Over one-third of the schizophrenics show manic features. And to a great percentage of the rest the term introversion, in the sense of increased interest of one's own person, is inapplicable. Kretschmer's classifications, also revolving around the schizophrenic-manic axis, are more realistic, and the characters which he describes—cyclothymics and schizothymics—are more alive and more convincing but they too are open to objection. While the term schizophrenia applied to dementia precox patients is convincing, the term schizothymia applied to normals is impossible and misleading. The inadequacies and contradictions (of normals) is based upon the symptomatology of the morbid. Further, just as the majority of people are neither introverts nor extraverts, so they are neither cyclothymics nor schizothymics. Another classification is proposed according to which people may be divided into those who have good capacities for some sort of activities or emotions and not for others, and those whose capacities are even. In the former there is an uneven distribution of dynamia and in the latter a uniform distribution of dynamia. Heterophrenic is the term proposed for the one and homophrenic for the other. In this scheme of things, the types of Jung, Kretschmer and others, also those one meets in life, find their places without any manipulations. This formula refers to something innate, not to something related to the environment. Nor does it refer to disease conditions wherein several features go together. Furthermore this formula provides for a line to be drawn between the distance when a trait is a manifestation of a normal function and when this same trait is a manifestation of a psychosis. 4 references.

Backache as a Psychosomatic Problem. *Alfred Blazer, Croton-on-Hudson, N. Y. Am. J. Psychotherap. 2:441-47, July 1948.*

A case of a man of 40 years of age, suffering from backache, is cited in order to demonstrate how deep emotional conflict can produce physical symptoms. The dynamics of the patient's character structure were as follows: at every step in the patient's development from infancy, he was thwarted and frustrated by the rejecting mother. Her excessive demands for conformity and cleanliness, her ambitious, unsympathetic perfectionism and lack of true warmth, made it certain that at every stage in his development which required sympathetic weaning from

one stage of maturation to the next would be a struggle. From early childhood, the patient was constantly in an inner turmoil. In order to be accepted, he had to yield autonomy. In renouncing autonomy, he created inner resentment which in turn had to be suppressed. Whatever course he took generated anxiety and tension. While each stage of growth was difficult, his mother's attitude to his sexual development was a final and crippling burden. In the supportive orbit of his first marriage, the patient was able to reach a compromise with life which, while one-sided and unsatisfactory, permitted him to function. When his first wife died and he had to return to the competitive, hostile atmosphere of the parental home, his compromise broke down and he regressed to an earlier defense pattern: psychosomatic illness. Various factors caused the selection of the lumbar region of the spine for the seat of the psychic disorder. A brief, modified analytic approach was used in this case. The therapist was at all times permissive, uncritical, friendly and accepting. He made no exaggerated demands and never held up inordinate goals. The patient was given no opportunity to become resentful of the ideal mother as he had of the real mother because the therapist did not impose judgment, yet was invariably helpful and willing to assist the patient solve each problem as it arose. While the brief therapy employed in this case will not, of course, effect a deep personality change, it may, if successful, be remarkably effective in resolving inner conflicts which have paralyzed the patient in his attempts to find a satisfactory mode of functioning. When somatic symptoms have resulted from tensions caused by these inner conflicts, these, too, may be alleviated.

Acute Spastic Ileus on Hysterical Basis. *Frederick Vogel, Long Island College Hospital, Long Island, N. Y.* *Am. J. Psychotherap.* 2:448-61, July 1948.

A case of acute spastic ileus is described in a white male patient, aged 44 years. The explanation of the patient's present condition was sought in his psychoneurotic background and his pathologically unstable character. His neurosis manifested itself predominantly in a sexual maladjustment. The exact cause of it could not be ascertained but it seemed safe to assume that the patient's emotional insecurity and quest for affection on the one hand and the spastic pattern of his neurotic defense reactions on the other offered the psychoneurotic background for a spastic ileus which as such became an acute medical emergency. In consideration of these facts a conservative treatment was applied which proved entirely satisfactory. 6 references. 6 figures.

ERRATUM

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Page 588—We much regret that some words were dropped inadvertently from the review of BIOSYNTHESIS by Francis J. Mott. This error had the effect of making it seem as if Mott's thesis consisted of a claim that the intrauterine configurations were imposed upon the fetus by plant and animals forms. The erroneous paragraph occurs at the foot of p. 588. It should be deleted and the following substituted:—

“In order that I may not lose Mott's sharp and perfectly definite thesis in a maze of comment on minor issues, let me here leap straight to the point. He states unequivocally that the *libido* is simply the configurational sense of nuclearity imposed upon the fetus by the universal Design or Gestalt which had earlier likewise guided the creation of the plant and animal forms. The *libido* is therefore, in Mott's view, simply the appearance in human feelings of the same configurational trend which, operative in the material world, has guided the whole of creation. Therefore, configurationally, Mott asserts, the external and the subjective universes are one. Configurationally, mind and matter are united in a single pattern.”

We also regret that, through editorial mistake, the title M.D. was added to Dr. Mott's name.